Patient-Centered Healthcare Solution

Expanding access to quality care without expanding government assistance

The Patient-Centered Care Act (SB 459/SB 460) would create a free market alternative to the Medicaid Expansion proposals currently under consideration.

The legislation creates the regulatory infrastructure that enables a low cost, high quality care, free market environment within the confines of the ACA.

The bills would also provide for the conversion of current Medicaid enrollees to low cost, high quality Qualified Health Plans featuring direct primary care services and high deductible health plans.

A patient-centered healthcare solution would:

- Expand access to quality care without expanding government assistance
- Return healthcare decision-making to doctors and patients
- Promote the return of insurance to risk management not benefit management
- Limit government control of health plans to definition of minimum essential benefits
- Protect patient health information from government
- Significantly reduce the costs for quality care yielding savings for taxpayers and a boost to our economy

SENATOR PATRICK COLBECK * www.SenatorPatrickColbeck.com * Facebook: facebook.com/senatorpatrickcolbeck

SB 459

Insurance; health; qualified health plans and private exchanges; establish in this state to ensure access to quality health care. Insurance: health; Health: planning; State agencies (existing): insurance and financial services

A bill to ensure access to quality health care and the availability of qualified health plans in this state without expanding government assistance programs; to promote the availability and affordability of health care coverage in this state; to create a mechanism for residents of this state to secure essential health benefits; to establish a regulatory program for a private marketplace and data interface; to create a fund; to provide for the powers and duties of certain state and local governmental officers and entities; and to allow for the promulgation of rules.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 1. (1) This act shall be known and may be cited as the "patient-centered care act".

(2) As used in this act, the words and phrases defined in sections 3 to 5 have the meanings ascribed to them in those sections.

Sec. 3. (1) "Department" means the department of insurance and financial services.

(2) "Director" means the director of the department.

(3) "Exchange" means an entity licensed under this act to provide a marketplace for residents to secure essential health benefits through a qualified health plan or government assistance program.

(4) "Federal act" means the patient protection and affordable care act, Public Law 111-148, as amended by the health care and education reconciliation act of 2010, Public Law 111-152.

(5) "Fund" means the low-income trust fund created in section 11.

(6) "Government assistance program" means a program of health care assistance offered by a federal, state, or local governmental entity including, but not limited to, medicaid, medicare, the MIChild program, the veterans health administration, and any other program of health care assistance identified by the department.

Sec. 5. (1) "Medicaid" means a program for medical assistance established under title XIX of the social security act, 42 USC 1396 to 1396w-5, and administered by the department of community health under the social welfare act, 1939 PA 280, MCL 400.1 to 400.119b.

(2) "Medicare" means the federal medicare program established under title XVIII of the social security act, 42 USC 1395 to 1395kkk-1.

(3) "Qualified health plan" means a benefit plan that is certified as a qualified health plan under section 7.

(4) "Resident" means an individual who is a citizen of the United States, who voluntarily lives in this state with the intention of making his or her home in this state and not for a temporary purpose, and who is not receiving public assistance from another state.

Sec. 7. (1) For the purpose of available coverage choices for residents, the department shall certify as a qualified health plan a benefit plan that complies with 42 USC 18021 and that meets the requirements of this section.

(2) In certifying a benefit plan as a qualified health plan under this section, the director shall ensure that the benefit plan meets all of the following requirements:

(a) Is offered by a health insurer issuer as described in 42 USC 18021(a)(1)(C).

(b) Offers access to quality health care by providing coverage under a package of benefits that is equal to or greater than that required as an essential health benefits package as defined in 42 USC 18022. The department shall consider all of the following when makings its determination under this subdivision:

(*i*) The availability in the package of benefits under a traditional insurance option.

(*ii*) The availability in the package of direct primary care services.

(*iii*) The availability in the package of fee-for-service options, but only if there is a sufficient balance in the benefit

package account to cover minimum essential benefits in combination with other coverage.

(*iv*) The availability in the package of any combination of the options described in subparagraphs (*i*) to (*iii*).

Sec. 9. (1) Subject to subsection (7), the department shall establish and administer a program to license private entities as an exchange in this state. The department shall develop an application form and require the submission of documents and information sufficient to determine if the applicant is eligible for a license or renewal of a license as an exchange under this section. The director shall issue a license or renewal of a license to a person who applies to be an exchange in this state and who meets all of the following requirements:

(a) The individuals who are identified as being a part of or associated with the exchange are of good moral character as defined in section 1200 of the insurance code of 1956, 1956 PA 218, MCL 500.1200.

(b) The person submits with a license or license renewal application a plan of operation that details its ability to meet the requirements of this section.

(2) The department shall investigate and determine the merits of each application submitted by a person under this section. The department may request additional information from an applicant or licensee under this section. An applicant or licensee shall comply with requests for additional information from the department in a timely manner.

(3) In addition to criteria established by the department

under this section, the department shall determine that the exchange to be operated by the applicant or licensee meets all of the following requirements before issuing a license or license renewal under this section:

(a) Is designed to offer 1 or more qualified health plans to residents.

(b) Will comply with all data security requirements established for an exchange under this act.

(c) Is designed so that the enrollment process provides a resident with the option to provide information necessary to determine the resident's eligibility for government assistance programs.

(d) Will ensure accuracy in all aspects of the operation of the exchange.

(e) Will operate with fiscal solvency.

(f) Will comply with all data security requirements established by the department under this act.

(g) Will seamlessly and securely make data transmissions that are required under this act.

(h) Will convey government assistance program eligibility information to residents.

(i) Will comply with any other applicable federal or state law governing the privacy of any personally identifying information or health or medical information of a resident.

(j) Will ensure that a resident who is eligible for a government assistance program receives a discount from the base cost of a benefit package in a manner that will enable the resident

to realize 100% of the value of the government assistance program.

(k) If the department determines that enrollment in a government assistance program through an exchange is not allowed under the federal act, will issue a coupon to a resident who is eligible for a government assistance program that may be redeemed by the resident at the appropriate government assistance program portal or other appropriate state or local agency.

(4) In developing security standards and data transmission requirements applicable to an exchange under this act, the department shall ensure all of the following:

(a) That no information beyond that information necessary to determine eligibility for government assistance programs is transmitted to any person outside of the exchange.

(b) That a standardized data schema is used for exchanges to collect the information that is necessary to determine eligibility for government assistance programs and convey information pertaining to that eligibility.

(5) The department shall develop and maintain a government assistance program portal for use by exchanges and, if the department determines appropriate, by government assistance programs, that facilitates the receipt and transmission of data but only for uses approved by the department under this act.

(6) The department shall reconcile eligibility for multiple government assistance programs to ensure that benefit eligibility is determined in the context of cumulative benefits received as a means of reducing fraud.

(7) The department shall request the United States department

of health and human services for a determination of whether an exchange to be licensed under this section will be considered to meet the qualifications of an exchange for the purposes described in 41 USC 13031. If the department determines that an exchange to be licensed under this section will not meet the qualifications of an exchange for the purposes described in 41 USC 13031, the department shall only issue a license under this section to nonprofit entities that meet those qualifications.

Sec. 11. (1) The low-income trust fund is created within the state treasury.

(2) The state treasurer may receive money or other assets from any source for deposit into the fund. The state treasurer shall direct the investment of the fund. The state treasurer shall credit to the fund interest and earnings from fund investments.

(3) Money in the fund at the close of the fiscal year shall remain in the fund and shall not lapse to the general fund.

(4) The department is the administrator of the fund for auditing purposes.

(5) The director shall expend money from the fund only for the purposes of implementing and administering this act and for any other purpose enumerated in this act.

(6) If the social welfare act, 1939 PA 280, MCL 400.1 to 400.119b, is amended to provide that recipients of the medical assistance program and the MIChild program are migrated from those programs and enrolled in qualified health plans that include a health savings account component through an exchange as provided in this act, and money saved from that migration is deposited into the

fund, the director shall expend the amount of money deposited into the fund for the benefit of those former recipients to pay any deductibles under high-deductible health insurance plan components of a qualified health plan as triggered by the health care services needed by the former recipients. The director shall continue to pay the deductibles for those former recipients until such time as each former recipient's individual health savings account balance is determined by the department to be actuarially sufficient to cover his or her deductibles.

Sec. 13. The department may promulgate rules under the administrative procedures act of 1969, 1969 PA 306, MCL 24.201 to 24.328, that it determines necessary to implement and administer this act.

Human services; medical services; all medical assistance program recipients; enroll in certain certified qualified health plans.
Human services: medical services; Insurance: health

A bill to amend 1939 PA 280, entitled

"The social welfare act,"

(MCL 400.1 to 400.119b) by adding section 105c.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

SEC. 105C. (1) BEGINNING JANUARY 1, 2015 OR UPON TERMINATION OF THE CURRENT CONTRACTED HEALTH PLANS, ALL CURRENT MEDICAL ASSISTANCE RECIPIENTS WILL BE MIGRATED TO AN INDIVIDUAL HEALTH SAVINGS ACCOUNT WHEREIN THEY CAN PURCHASE A QUALIFIED HEALTH PLAN WITH THE BALANCE OF FUNDS PROVIDED BY ELIGIBLE GOVERNMENT ASSISTANCE.

(2) ELIGIBLE GOVERNMENT ASSISTANCE AMOUNT IS DETERMINED ON AN ANNUAL BASIS AS A RESULT OF SURVEYING THE COMMERCIAL HEALTH CARE MARKET IN THE STATE AND ESTABLISHING THE AVERAGE COST OF A QUALIFIED HEALTH PLAN THAT IS COMPOSED OF DIRECT PRIMARY CARE SERVICES AND A HIGH-DEDUCTIBLE INSURANCE PLAN. THE AVERAGE COST

WOULD BE THE GOVERNMENT ASSISTANCE AMOUNT.

(3) MIGRATION SAVINGS IS THE DIFFERENCE BETWEEN THE CURRENT MEDICAID COST FOR ALL ENROLLEES MINUS THE AVERAGE GOVERNMENT ASSISTANCE AMOUNT FOR ALL ENROLLEES TIMES THE NUMBER OF ENROLLEES.

(4) A PORTION OF THE MIGRATION SAVINGS DESCRIBED IN SUBSECTION (3) SHALL BE DEPOSITED INTO THE LOW-INCOME TRUST FUND AT AN AMOUNT NOT TO EXCEED THE AMOUNT NECESSARY TO PAY THE LESSER OF GAP INSURANCE OR THE AVERAGE DEDUCTIBLE UNDER A HIGH-DEDUCTIBLE HEALTH INSURANCE PLAN COMPONENT OF A QUALIFIED HEALTH PLAN UNTIL THE INDIVIDUAL'S HEALTH SAVINGS ACCOUNT BALANCE HAS BEEN DETERMINED ACTUARIALLY SUFFICIENT TO COVER THE DEDUCTIBLE OF THE HEALTH INSURANCE PLAN WITHOUT MONEY FROM THE LOW-INCOME TRUST FUND.

(5) BEFORE IMPLEMENTING THE PROVISIONS OF THIS SECTION, THE DEPARTMENT OF COMMUNITY HEALTH SHALL REQUEST A WAIVER FROM THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

(6) AS USED IN THIS SECTION:

(A) "LOW-INCOME TRUST FUND" MEANS THE LOW-INCOME TRUST FUND CREATED IN SECTION 11 OF THE PATIENT-CENTERED CARE ACT.

(B) "QUALIFIED HEALTH PLAN" MEANS THE QUALIFIED HEALTH PLAN CERTIFIED UNDER THE PATIENT-CENTERED CARE ACT.

Enacting section 1. This amendatory act does not take effect unless Senate Bill No. 459 of the 97th Legislature is enacted into law.

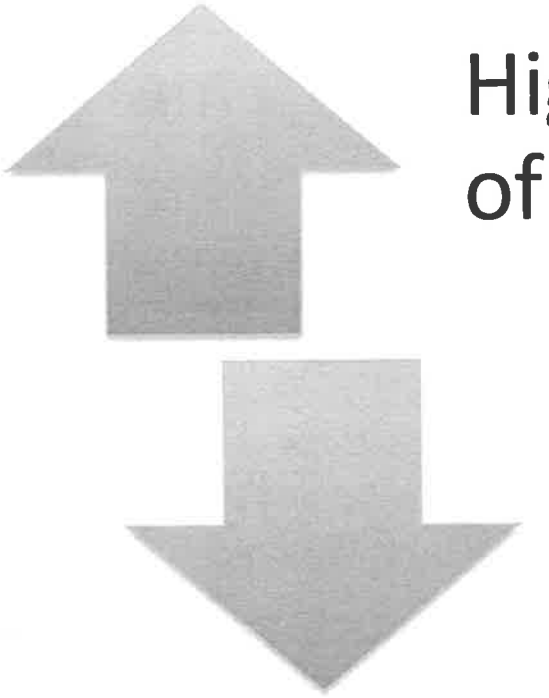
PATRICK COLBECK
STATE SENATOR
DISTRICT 7

Patient-Centered Care Solution

Expanding access to quality care without expanding government assistance

Free Market Opportunity

PATRICK COLBECK
STATE SENATOR
DISTRICT 7



Higher quality of care

Improved physician access with preventative care emphasis

Lower costs

More than 50% reduction in healthcare costs

*No waivers required**

*Two are pursued to improve customer experience and retain federal Medicaid funding

The Patient-Centered Care Solution

PATRICK COLBECK
STATE SENATOR
DISTRICT 7

- Make quality of patient care for all citizens the first priority
- Expand access to quality care without expanding government assistance
- Convert existing Medicaid population to commercial insurance featuring Direct Primary Care Services plus High-Deductible Health Plans within a Health Savings Account
- Return healthcare decision-making to doctors and patients
- Return insurance to risk management not benefit management
- Limit government role to determination of government assistance eligibility
- Protect patient health information from government
- Significantly reduce the costs for quality care yielding savings for taxpayers and a boost to our economy

Solution Comparison

PATRICK COLBECK
STATE SENATOR
DISTRICT 7

ID	Healthy Michigan (HB 4714)	Patient-Centered Care (SB 459/460)
1	Expands Medicaid	Expands access to quality health care without expanding government assistance
2	Poor quality care	High quality care
3	Higher cost health care for many to subsidize lower cost health care for some	Lower cost health care for all
4	Increased government spending ($2B)	Decreased government spending (-$7B)
5	Increases debt risk on future generations	Lowers debt risk for future generations
6	High risk implementation	Low risk implementation
7	Discourages job growth	Encourages job growth
8	Converts uncompensated care to undercompensated care	Converts uncompensated and undercompensated care to fully compensated care
9	Promotes current third party payment model with minimal price transparency	Promotes price transparency
10	Promotes big government	Promotes limited government

A look at the numbers…

PATRICK COLBECK
STATE SENATOR
DISTRICT 7

State of Michigan	Michigan Employers	Patient-Centered Care Solution

• Over $15B/yr spent on government healthcare assistance
  • $6500/person/yr on average
  • $5000/person/yr for single adults
• State of Michigan spends ~$280M/yr on healthcare insurance for its employees
	• Over $31B/yr spent on healthcare
	  • 5.7M employees insured by employer
	  • MI $5385/person/yr
	  • Ohio $4,671/person/yr
		• A Qualified Health Plan would cost as little as $2052/person/yr
		  • Direct Primary Care Services cost $900/person/yr
		  • High-Deductible Health Plans cost as little as $1152/person/yr

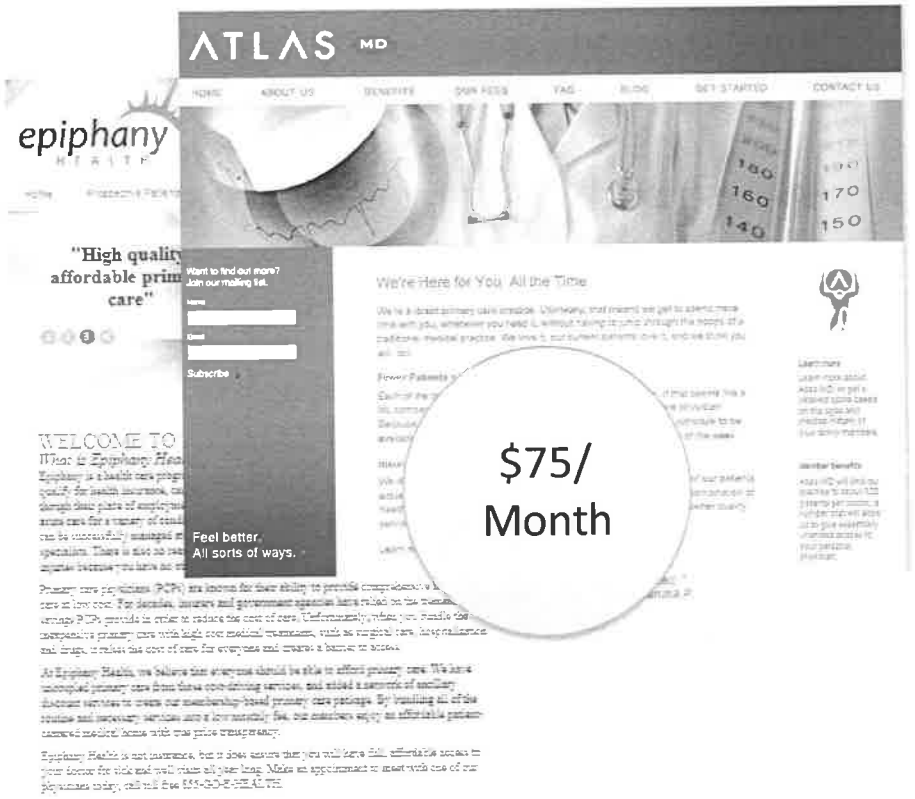
Potential Savings: >$7B/yr	Potential Savings: >$15B/yr	*59% LESS EXPENSIVE THAN MEDICAID WITH BETTER CARE!*

What would lower healthcare costs mean for MI job growth? Medical tourism?

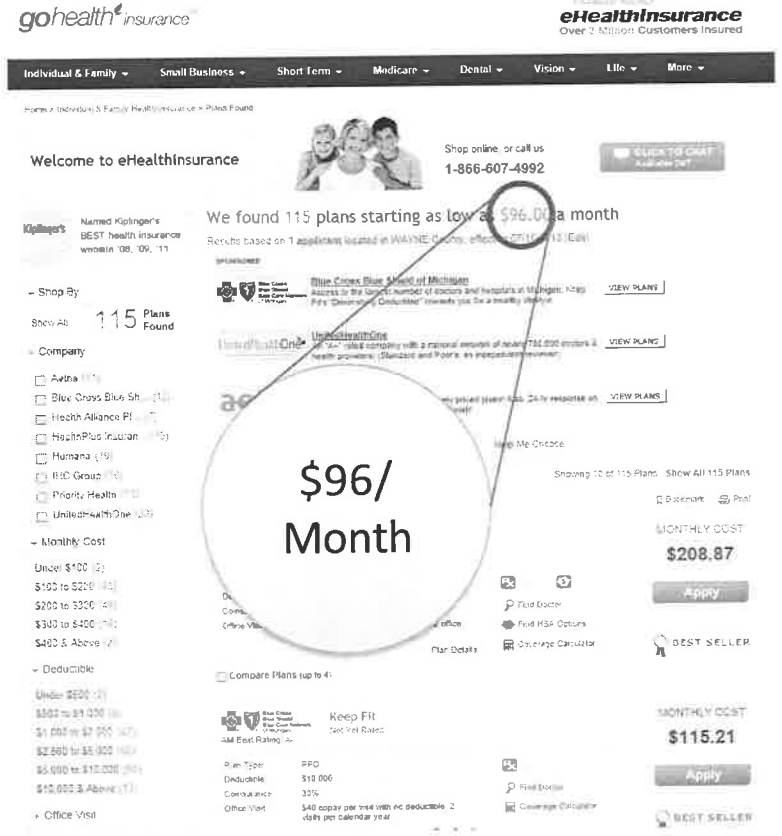
It is already working…

PATRICK COLBECK
STATE SENATOR
DISTRICT 7

Direct Primary Care Services



High-Deductible Health Plans via Private Health Exchanges



Bill Package

PATRICK COLBECK
STATE SENATOR
DISTRICT 7

SB 459: Regulatory Infrastructure

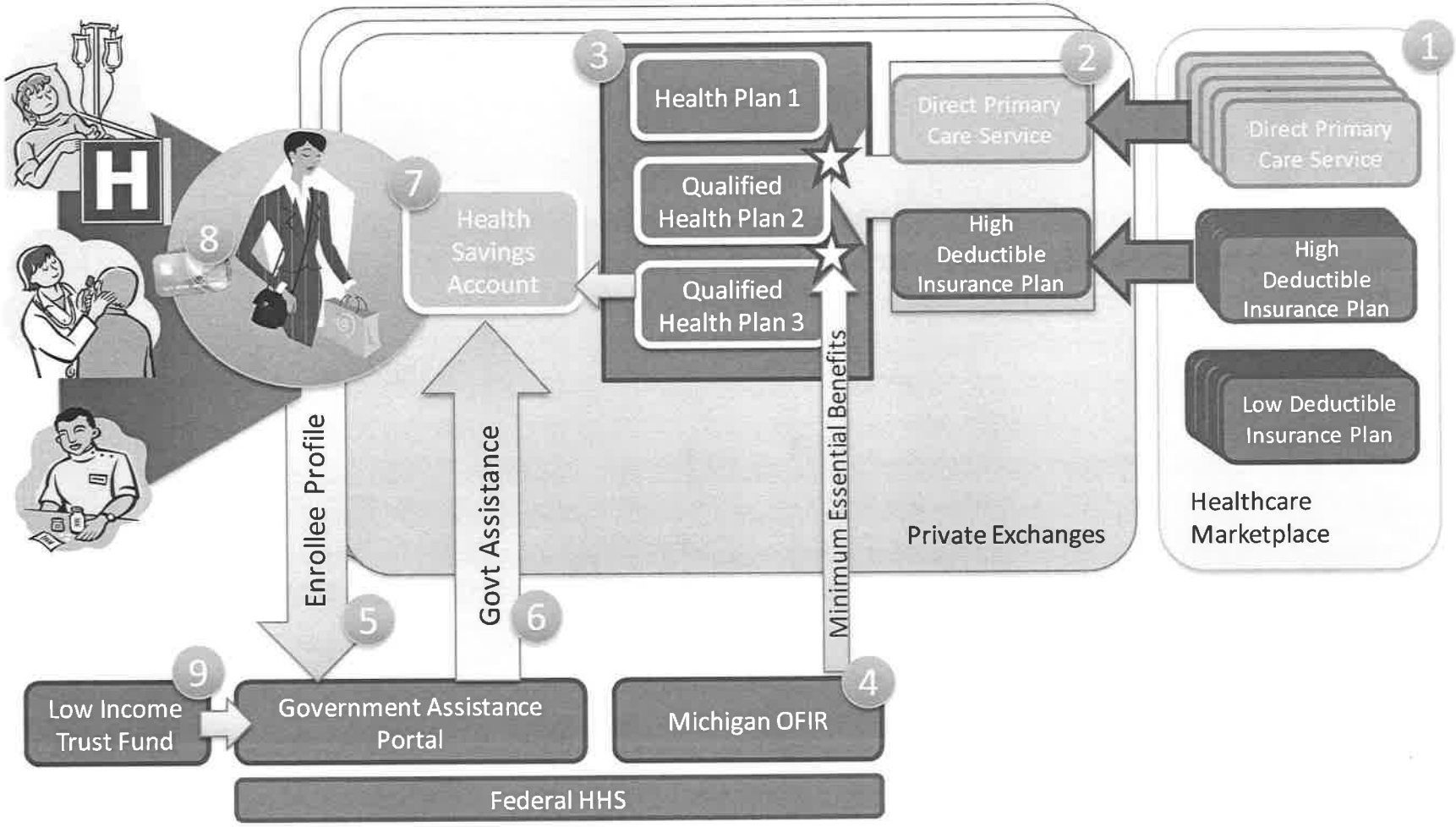
- Provides the regulatory infrastructure that enables a low cost, high quality care free market environment within the general confines of the ACA.
- Low Income Trust Fund envisioned by Senator Caswell
  - Disbursement scope limited to "gap insurance" for Medicaid enrollees that invoke the high deductible component of their Qualified Health Plan.
- *WAIVER: Government Assistance thru Private Exchange*
  - *Contingency Option A: Redeem coupon at Government site/facility*

SB 460: Conversion of Current Medicaid Population to QHP

- Converts the existing Medicaid population to a Qualified Health Plan featuring direct primary care services and a high deductible health insurance plan within a tax-exempt health savings account (HSA).
- *WAIVER: Conversion of Current Medicaid Population to DPCS-based QHP*
  - *Contingency Option A: Drop federal Medicaid assistance and continue with conversion*
  - *Contingency Option B: Maintain current system*

How it works…

PATRICK COLBECK
STATE SENATOR
DISTRICT 7



The case for a different solution…

PATRICK COLBECK
STATE SENATOR
DISTRICT 7

Why give up "free" money from the federal government?

- The federal government is borrowing the money it is using to pay us
- There is a high risk that the federal government will reduce payments and/or increase mandates
- GDP is increasing at 2-3% rate. Medicaid is increasing at 8% rate
- By lowering expenses in our state, we avoid state and local tax increases to pay for government employees
- Medicaid Expansion is simply a bait and switch by the federal government handing over their liability for their policies to us
- Pursuit of solutions that LOWER costs benefit everyone in the state

Why shouldn't we expand government assistance to low income residents?

- Medicaid is NOT quality care
- Medicaid expansion will NOT solve cost-shift problem.
  - Medicaid recipients use ER 3X more than uninsured or privately insured
  - Medicaid only reimburses <60% of hospital costs
  - Uncompensated care is simply swapped for undercompensated care
  - Undercompensated care population will then use ER 3X more frequently
- Not sustainable

Why can't we simply modify HB 4714 or SB 422?

- HB 4714 expands government assistance via federal means and expands government control in general
- SB 422 expands government assistance via state means
- Why spend more money when we have the opportunity to spend less and still expand access to quality care?

Why not pursue a solution that benefits all 10,000,000 citizens rather than only 400,000?

- We should pursue the solution that benefits ALL of our citizens

Lower cost healthcare could even help Detroit…

PATRICK COLBECK
STATE SENATOR
DISTRICT 7

- Viable alternative to higher cost ACA plans
- Better benefits for city employees at lower costs
- The total cost of healthcare benefits City-wide in FY 2012 was approximately $275 million, of which approximately $177 million related to retirees*
- The General Fund's portion of healthcare costs in FY 2012 was approximately $204 million, of which approximately $150 million related to retirees*
- Potential to lower annual healthcare expenses by as much as 50% ($137M)
- Potential to lower $5B liability for retiree healthcare by as much as 50% ($2.5B)

Solution Comparison

PATRICK COLBECK
STATE SENATOR
DISTRICT 7

ID	Healthy Michigan (HB 4714)	Patient-Centered Care (SB 459+)
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THE SENATE
STATE OF MICHIGAN

COLUMN: Patient-Centered Healthcare Solution
Senator Patrick Colbeck
July 22, 2013

A lot of time, money and effort have gone into the promotion of the expansion of Medicaid in Michigan. It would be unfair to those who have worked so hard towards these ends to simply say no. While I have been and will continue to be an outspoken critic of Medicaid Expansion and its parent legislation, the Affordable Care Act (aka Obamacare), I have gone beyond simply saying no to highlighting the opportunity of the free market to better address the stated objectives of Obamacare: "lower costs, improve quality and coverage, and protect consumer choice". In order to take advantage of these free market alternatives, we also need to go beyond a discussion of expanding Medicaid to that of expanding access to quality care.

What are these free market alternatives? To date, they have admittedly been primarily anecdotal in Michigan. It has taken much effort and collaboration over the past few months with free market proponents across the country to finally solidify these options in the form of legislation. The Patient-Centered Care Act (SB 459 and companion legislation) has now been introduced as a proposal to fill this void.

SB 459 provides the regulatory infrastructure that would enable a low cost, high quality care free market environment within the confines of the ACA. This regulatory infrastructure includes the development of a government assistance portal and licensing guidelines for multiple private exchanges that would serve as the point of contact for individuals and organizations that are required to purchase a qualified health plan under the provisions of the Affordable Care Act. The bill also features the establishment of a Low Income Trust Fund similar to that envisioned by Senator Caswell in his SB 422 except that the scope of disbursements for the fund would be limited to "gap insurance" for current Medicaid enrollees that invoke the high deductible component of their Qualified Health Plan.

A second piece of companion legislation to be introduced shortly would convert current Medicaid enrollees to low cost, high quality Qualified Health Plans featuring Direct Primary Care Services and High Deductible Health Plans wrapped within a Health Savings Account. Not only would the enrollees receive better care under commercial health plans rather than Medicaid, both the state and federal governments would save billions in healthcare costs yielding the potential for a much lighter load on hardworking taxpayers.

The net impact of both of these bills will be to lower healthcare costs for everyone in our state while promoting better quality of care. So much of the discussion to date has focused on the estimated 400,000 individuals in the Medicaid Expansion pool. These bills broaden the discussion by introducing a solution that promises to benefit all 10,000,000 Michigan residents. In the process of doing so, we expand the number of residents who can afford to purchase quality healthcare services without expanding government assistance.

For too long, government programs have been designed to divide us into demographic silos pitting one group of citizens against another. Per our Michigan Constitution, our government was instituted for the equal benefit of us ALL. It is about time that our policies reflected this core principle.

Our Governor has shown great leadership in his pursuit to "reinvent Michigan". The Patient-Centered Care Act provides us with an opportunity to do just that while still honoring the core principles that make Michigan a great state. We need to go beyond simply keeping up with the other states falling in line to implement Obamacare without significant innovation. We have an opportunity to create a healthcare system in Michigan that goes beyond taking care of segments of our society to easing the burdens of everyone in our society. Creating a healthcare system that helps all of Michigan's residents is truly Pure Michigan.

We are currently watching Detroit struggle through bankruptcy in large part because of out of control healthcare costs for city employees. This should be a wake-up call for legislators that we cannot continue to push these costs down the road and expect the problem to resolve itself. Rising healthcare costs can lead the state down the same path as Detroit if we don't get a handle on them now.

It is time to go beyond propagating a system where employers are forced to cut employee hours to avoid penalties from the federal government, to creating a new system where our healthcare costs are so low and yields such high quality of care that employers flock to our state to gain a competitive advantage over their rivals in other states and countries. We need to go beyond coping with a broken healthcare system and create one that is the envy of the free world...one that our Canadian friends under socialized medicine would cross the bridge in droves to take advantage of. It is time to take advantage of the free market and reinvent our healthcare system in Michigan for the betterment of all of our citizens.

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NFIB®
The Voice of Small Business

MICHIGAN

To: Honorable Senator Patrick Colbeck and Members of the Senate Government Operations Committee

From: Charles Owens, State Director

Date: July 31, 2013

RE: Patient Centered Care Act, SB 459 and 460

We are writing to voice our support for Senate Bills 459 and 460 sponsored by Senator Patrick Colbeck that seek a free market – patient centered approach to expanding health care in Michigan.

In the four decades that NFIB has been advocating for accessible and affordable health care for small business and their employees, we have always supported a consumer driven - market based model for reform. The proposal put forth by Senator Colbeck includes many of those principles.

As the recent fumbles in the implementation of the Affordable Care Act have illustrated, government is the problem with our health care delivery, not the solution. Growing consumer and patient choice, not government, is the answer to fulfilling the promises of affordable care.

How unfortunate it is that a proposal that puts patients and consumers in charge of their own care is now viewed as "radical" or "experimental" in a country where such concepts were once the norm and government-centric programs were the exception.

We urge the committee and all Michigan lawmakers to give this proposal serious consideration as an alternative to the big government, central planning approach to health care expansion represented by the effort to expand Medicaid in Michigan.

Thank you for your support of Michigan small business.

National Federation of Independent Business – MICHIGAN
115 W. Allegan St., Suite 310 ♦Lansing, MI 48933♦517-485-3409♦Fax 517-485-2155♦www.nfib.com

Kenneth A. Fisher, M.D.

July 30, 2013

Members of the Government Operations Committee:

We are now in the midst of a debate regarding the expansion of Medicaid as described in the Affordable Care Act (ACA). It appears that for budgetary reasons there is a sense of urgency for a decision.

However, just as the Supreme Court found that states including Michigan have the option of accepting this form of Medicaid expansion, the Court also put no time limit on that decision. One must keep in mind that House Bill 4714 is not in actuality a reform bill, but essentially expands the present Medicaid Program. Any alteration to Medicaid while accepting Federal dollars for the expansion is in reality a fig leaf as the ACA gives final authority to the Secretary of Health and Human Services regarding any details. There is no doubt that initially Medicaid expansion would be a financial windfall for Michigan, though at the expense of a financially overextended Federal Government. Under the present circumstances this windfall becomes a considerable expense for our state in later years.

However, Docs4PatientCare has an overwhelming non-financial reason to be against expanding the present Medicaid program. Multiple retrospective and a recently published excellent prospective study have demonstrated that for medical/surgical conditions, having present day Medicaid is no better and in some studies worse than having no insurance. Medicaid coverage did provide protection for some recipients against the recently exposed highly excessive hospital charges. Medicaid also provides for minimal nursing home care. We support a plan that provides excellent care that will by saving resources allow for expanding coverage to more of our citizens.

We believe a market solution will improve care for our Medicaid patients that also enhances coverage and at significantly less cost. State Senator Patrick Colbeck has introduced bills that while still in compliance with the ACA would have several advantages. The state would provide funds for Medicaid recipients in a health savings account for direct care contracts and other health related expenses and for insurance to cover large hospital expenses.

Direct Care Contracts allow patients to select a physician of their choice who has opted for a cash alternative to her/his practice. Fees are paid monthly usually for about $80.00/month with the physician arranging for large discounts for cash payments out of their health savings account for laboratory and radiological testing.

I personally know of many physicians in Michigan who are ready to practice in this model. Presently many physicians cannot afford to see Medicaid patients because of the extremely low reimbursements.

Using Senator Colbeck's plan the Medicaid patient would have the resources to pay the contracted physician a respectable amount making the patient attractive in the health care market. This eliminates one of the present Medicaid patient's greatest problems, finding a treating physician and not using the emergency room for routine medical needs.

In Massachusetts, when enacting a forerunner of the ACA, emergency room visits have dramatically increased. A system providing health savings accounts along with catastrophic insurance to Medicaid patients in Indiana has demonstrated tremendously improved care along with considerable savings.

Senator Colbeck's plan also has the advantage that it is not only in compliance with the ACA, but also causes less employer insurance dropout as has happened in Arizona with ACA Medicaid expansion. As significant savings accrue as a result of this plan, funds could be used to improve payment for nursing home and other care needs.

Thus the question is not the approval of presently planned Medicaid expansion, but rather can we initiate a superior option for Medicaid recipients, putting the patient and not the bureaucracy as the central figure in tandem with the physician to provide excellent cost- effective health care? Senator Colbeck's plan would improve Medicaid patients' access to physicians, improve their health, provide protection from economic catastrophe while helping to control inflated health care costs, and save the state significant resources.

Best Regards,

Kenneth A. Fisher, M.D.
Docs4PatientCare, MI Chapter President

To Our Esteemed Michigan Lawmakers:

This is a letter in support of Senator Pat Colbeck's Patient-Centered Care Proposal (SB-459) for Michigan's Medicaid program. As the events of this past month have shown us, we must be cautious before passing any legislation that will increase costs for our citizenry, particularly when Michigan's health care spending is already 45% of our budget. While advocates of the ACA and HB4714 will argue that the 'expansion' of Medicaid is 'free money' for the first few years, we all know that no government money is free and, that ultimately Michigan will be left with an unsustainable and underfunded liability.

Michigan does not have to look very far to see what our future holds if we expand Medicaid under the ACA. Massachusetts is 6 years ahead of us with Romneycare, the model for the ACA. Here is the breakdown of their state's 2012 budget according to the Wall Street Journal: health care spending has jumped 59% and is now 54% of their budget, Education has fallen 15%, Police and Fire dropped 11% and Roads and Bridges 23%. In Massachusetts, spending on healthcare is the highest per capita *on earth*. Michigan simply cannot afford to expand Medicaid under this legislation.

Senator Pat Colbeck's Patient-Centered Care Proposal (SB-459) is a bold model for Michigan's Medicaid enrollees that uses proven strategies to lower costs, increase preventative care and covered lives. The foundation of Senator Colbeck's proposal is a free-market solution that engages patients in their health and healthcare. Under the Senator's innovative plan, Michigan's Medicaid recipients will have control of their personalized health spending accounts; moving them from "open bar" healthcare where recipients spend other people's money and ignore costs to a "cash-bar" model where patients benefit from healthy behaviors and pay attention to costs. Our neighbor, Indiana, created a similar model for their Medicaid enrollees from 2007-2012. The Healthy Indiana Plan enjoyed 98% patient satisfaction scores and over 75% wellness participation (you read correctly). Once individuals are engaged in their care and paying attention to costs, they behave differently.

Detroit's bankruptcy has shown us that decisions made long ago can have devastating long-term effects. At a minimum, this should cause every Michigan lawmaker to pause and honestly consider all viable solutions, particularly since healthcare encompasses so much of our budget.

To remain globally competitive, Michigan needs a more sustainable model for our healthcare. We know what is not working; it would behoove us to consider models for care that are utilized by the most competitive economies in the world.

Senator Colbeck's Patient-Centered Care Proposal (SB-459) does just that.

Sincerely,

Matt McCord, MD

Secretary, Michigan Chapter of Docs4PatientCare.org

Ann Arbor, Michigan

Testimony for the Michigan Senate
Direct Primary Care as an alternative to PPACA
From the Insurance Agent point of View.
By: David J Powell, CLU, ChFC, CFP, RHU
President, DAVID J POWELL & Associates, LLC
July 31, 2013

Direct Primary Care is a majority of the usage in medical care from a health insurance standpoint. Research clearly shows that 60% to 75% of all claims submitted for processing to an insurance company are for Direct Primary Care.

With this understood, that does not mean that these claims represent the largest claims in terms of dollars paid out by insurance companies.

One Cancer, Heart bypass or premature baby claim may very well represent a larger dollar amount paid out on behalf of a consumer or business owner than the claims for primary care. The consideration is simply that when processing costs are added to actual claim dollar amounts, Direct Primary Care claims do, in fact, add up to a substantial piece of the overall cost of health insurance.

For the Atlas MD model, insurance is not even required for the model to work. There is no pre-existing condition or health status even considered. The medications needed do not determine if the patient will fit. But prescription savings found may well cover membership.

The problem and where health insurance becomes an integral part of the overall picture, is when service beyond Primary Care is needed. There is still the need of health insurance for catastrophic events or when the use of a specialist is dictated. There is still the possible need for the surgery or emergency service that is beyond the scope of Atlas MD membership. But by carving out Primary Care, or allowing a limited number of visits per year within the health insurance plan design, the cost (Premiums paid) of the health insurance plan can be substantially reduced.

The plan designs most often used to wrap around the Atlas MD model are either the H.S.A. qualified High Deductible Health Plans or modified Traditional Health Plans that contain first dollar elements that so many individuals and employer groups have used for years.

With the H.S.A. type plans, consumers can use the savings found to either pay their membership fees or to pay for the occasional small out of pocket expense of an office visit or the brand name prescription they may need outside of Atlas MD.

The modified Traditional Plan would include using a higher deductible than most normally purchase. I reduce the Office visits from unlimited, but still allow for 4-5 Office Visits per person per year. Normally these are used to see an occasional specialist. Sometimes they are used by a family member to see a long time family practice primary care physician. National studies show the average person only goes 2.5 times per year. Preventative is not counted as one of those since it is now covered 100%, so the need for unlimited visits disappears.

Secondly, with their ability to provide 4000+ generic prescription at cost, I place a $150 to $250 deductible on the prescription benefit.

By using this combination of higher deductible, limited office visits and a separate prescription deductible, I have saved a number of consumers and business owner as much as half on their insurance premiums.

This savings is NOT just a one year occurrence. We have a number that are still not back to the premiums they were paying 3 years ago.

The combination of Atlas MD and a well-designed catastrophic health insurance plan economically achieves the intent of PPACA without Big Government intrusion between a patient and their doctor.

Testimony Before the Government Operations Committee
Support for SB 459 and SB 460
Dr. Josh Umbehr, AtlasMD Founder
7/31/2013

Thank you for the opportunity to address the Government Operations Committee, we appreciate the opportunity to share our business plan with you.

AtlasMD is an innovative solution to the costly, regulated, bloated bureaucratic healthcare system. By infusing sound free market principles, we aim to revolutionize the American healthcare system. In 2.5 years we've grown over 300% more than expected, in large part because of our unique high value, low cost model of providing care. If healthcare is expensive b/c of red tape, then we are successful b/c we are able to slash through red tape.

The Problem –

- We're burning out our primary care doctors and this is the dirty secret of health reform that no one is talking about
- w/o a strong base of family doctors, the cost of care will spiral up and the quality will spiral down
- businesses can't afford the resulting increases in premiums and family can't tolerate the decreased quality of care
- Health reform is trying to fix a bureaucratic problem with more red tape and it won't work
- Health reform will drive private insurance out of the market and lead to single payer care

The Solution –

The AtlasMD clinic model slashes at the cost of care by offering: unlimited home, work, office and technology visits, eliminating copays, making all in-office testing and procedures free, and erasing all markups on medications and lab tests by utilizing wholesale distribution.

- In turn drastically decreases costly ER visits, urgent care visits, hospitalizations and specialists referrals, thus saving the system significantly
- Reduces operating costs by eliminating as much as 90% of the staff required to run an office
- Allows for decreases in insurance costs for local businesses as much as 50%

The Math –

- The average doctor has 3-4000 total patients (as high as 5600/dr locally) and sees an average of 40-50pts/day (as high as 60 though)
- national average for a doctor visit is 7-10 minutes...our average is closer to 1 hour
- direct primary care doctor will have around 600 pts/rc and will see 4-5pt/day/average but for maybe an hour or more each
- average doctor has 7-10 staff PER physician (to manage insurance claims) http://goo.gl/tZ7vV
- we can run well at 1 staff/nurse per 2 doctors
- 1/3 of doctors are interested in direct primary care, I believe the #s are higher
- our wholesale medications and labs are up to 95% off
- AtlasMD opened 09/02/2012, expected to grow at 10pt/mo, open 27 months and have 919 active patients now = fastest growing concierge practice per Tom Blue, CEO of aapp.org
- I've done a home visit for a patient almost every week for 2 years
- healthcare is a 2.2 trillion dollar industry...I believe we can cut 1/2 of that out
- we do 5-6k/mo in wholesale medications...at a modest 75% average savings, that's saving the system $15-18k/mo

The Moral Bankruptcy of Expanding Medicaid

Avik Roy

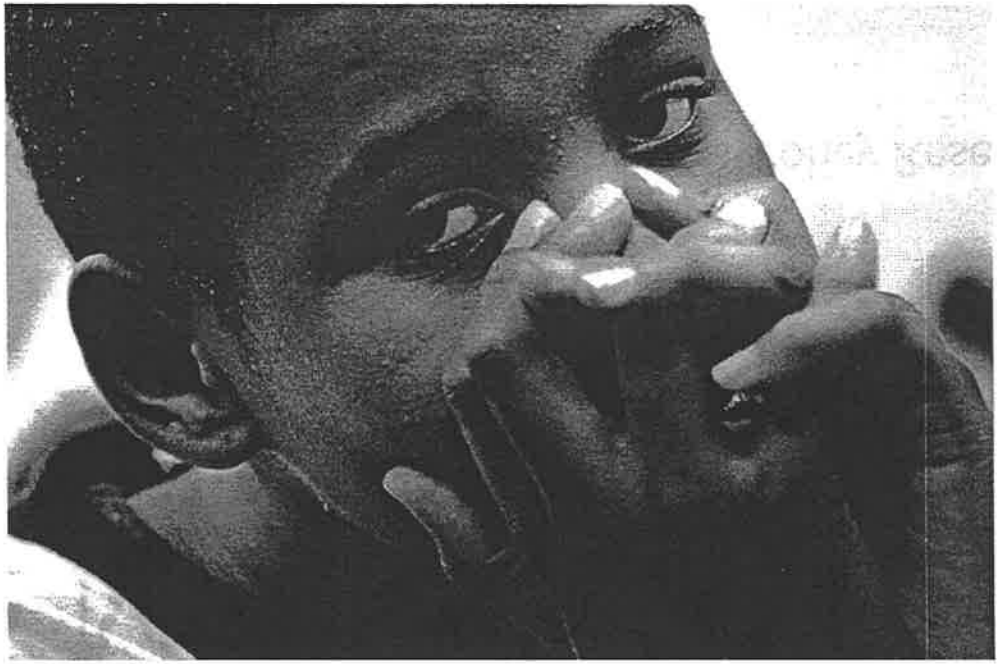
Senior Fellow, Manhattan Institute for Policy Research

Email: avik.roy@aya.yale.edu • Twitter: @avik

Facebook.com/forbesaroy

Deamonte Driver: The Face of Reform

- In 2007, Deamonte Driver, age 12, died of an untreated toothache



Deamonte Driver: The Face of Reform

- In 2007, Deamonte Driver, age 12, died of an untreated toothache
- But Deamonte was insured...by Medicaid
- Fewer than 1/6th of Maryland children on Medicaid have ever had a cavity filled
- In Maryland, for every dollar that private insurers pay a physician, Medicaid pays 66 cents
- **Physicians are forced to choose between economic stability and refusing to accept Medicaid**

Deamonte Driver: The Face of Reform

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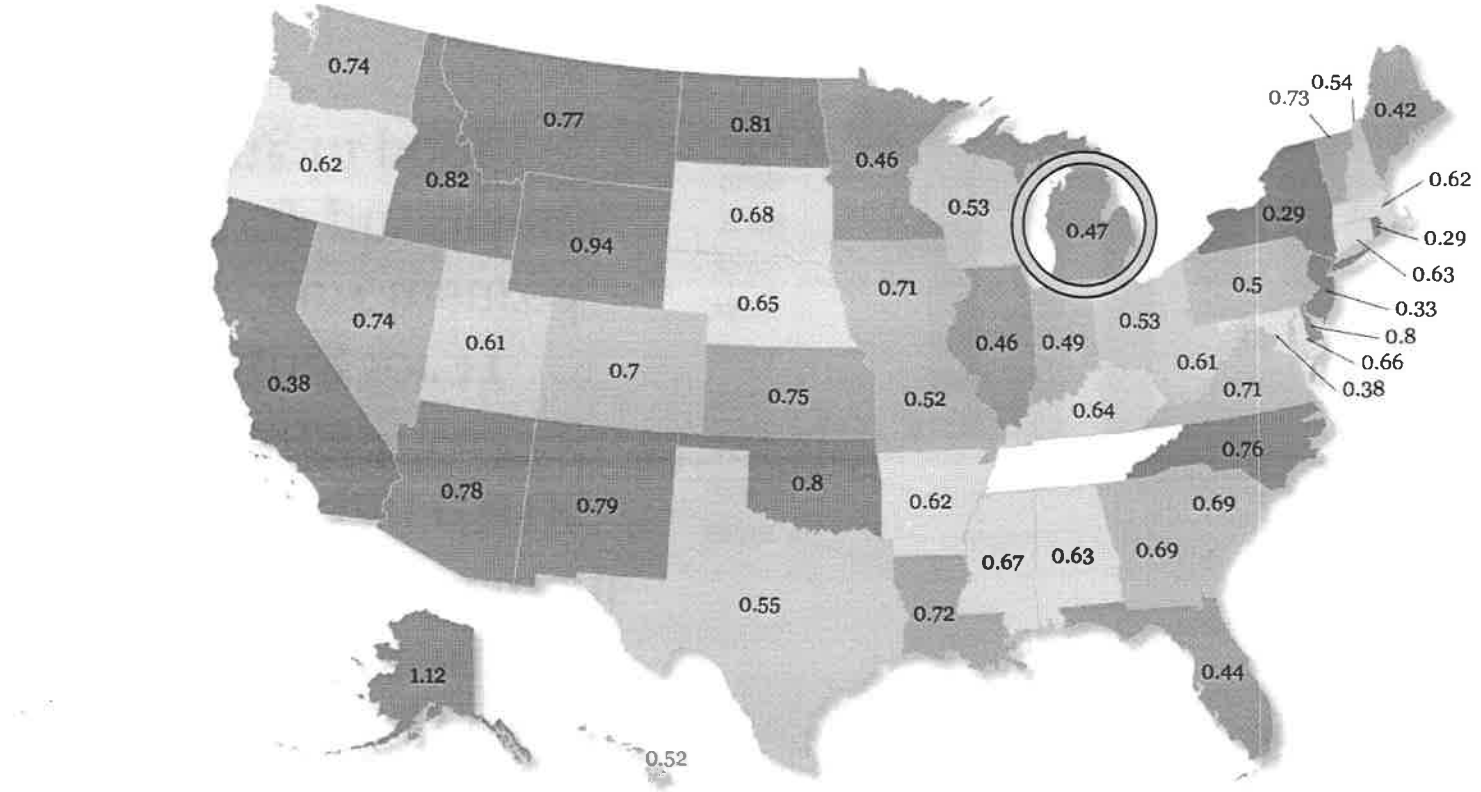
Deamonte Driver: The Face of Reform

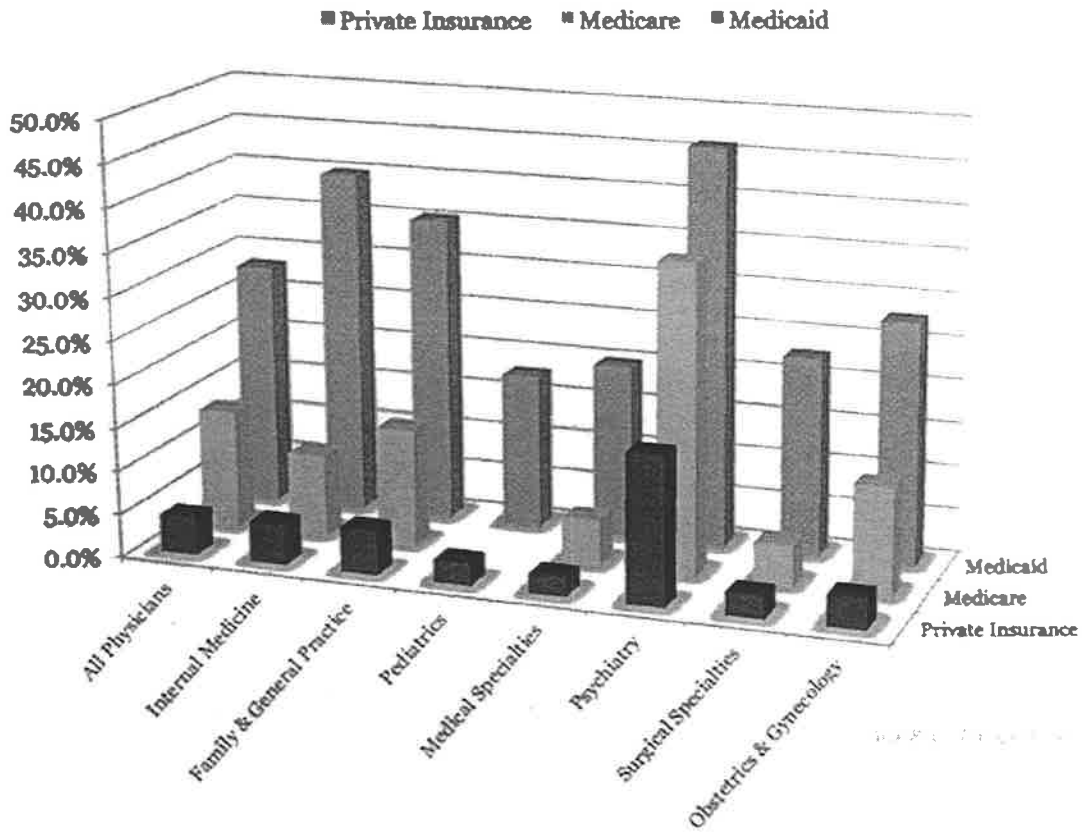
- In Michigan, for every dollar that private insurers pay a physician, Medicaid pays **47** cents



Health Insurance ≠ Health Care

- The ACA expands coverage, but with lower reimbursement
- Medicaid and CHIP expansions, accounting for 11 million new insured, underpay physicians, resulting in poor access
- 7 million Americans will lose higher-quality private coverage

Percentage of Physicians Who Accept No New Patients, by Insurance Status, 2008



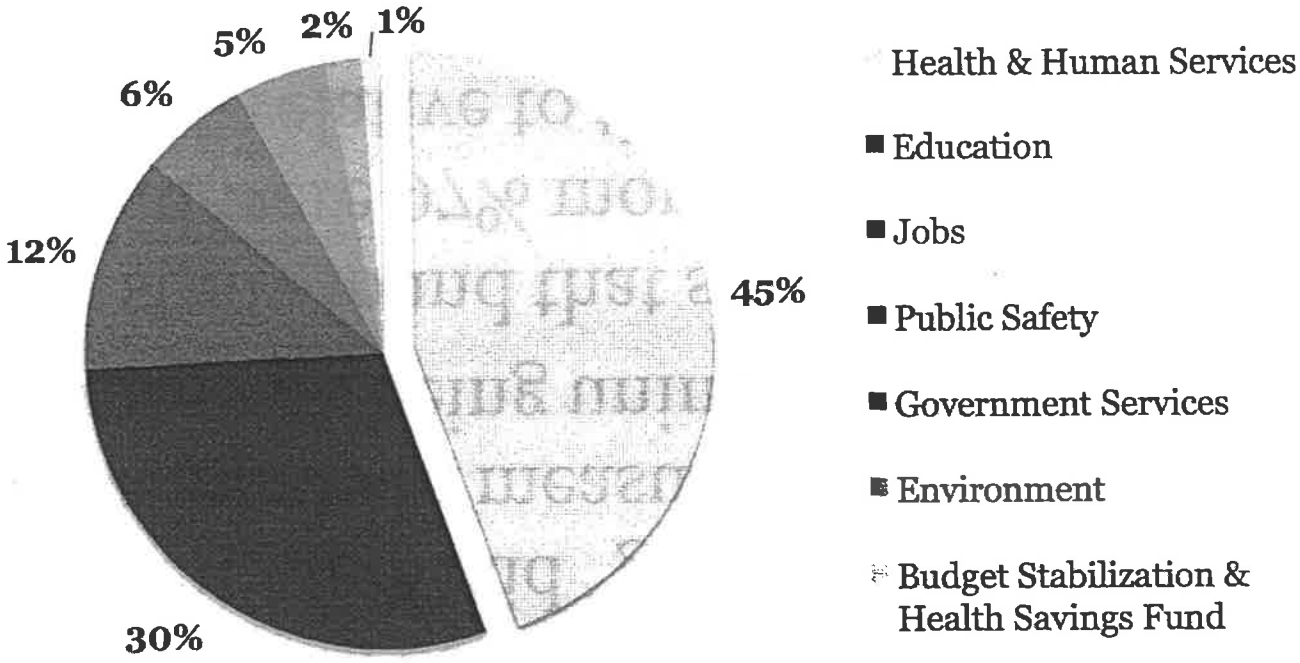
Medicaid Doesn't Improve Health Outcomes

- A randomized, controlled experiment in Oregon found that Medicaid "generated no significant improvements in measured physical health outcomes" vs. being uninsured
- A UVa study found that surgical patients on Medicaid were 97% more likely to die prior to discharge, relative to those with private insurance
  - And 13% more likely to die than those with no insurance at all
  - Study controlled its findings for age, gender, income, geography, surgical procedure, and prior health status

Medicaid Crowds Out Other Fiscal Priorities

- Health care already is 45% of state spending

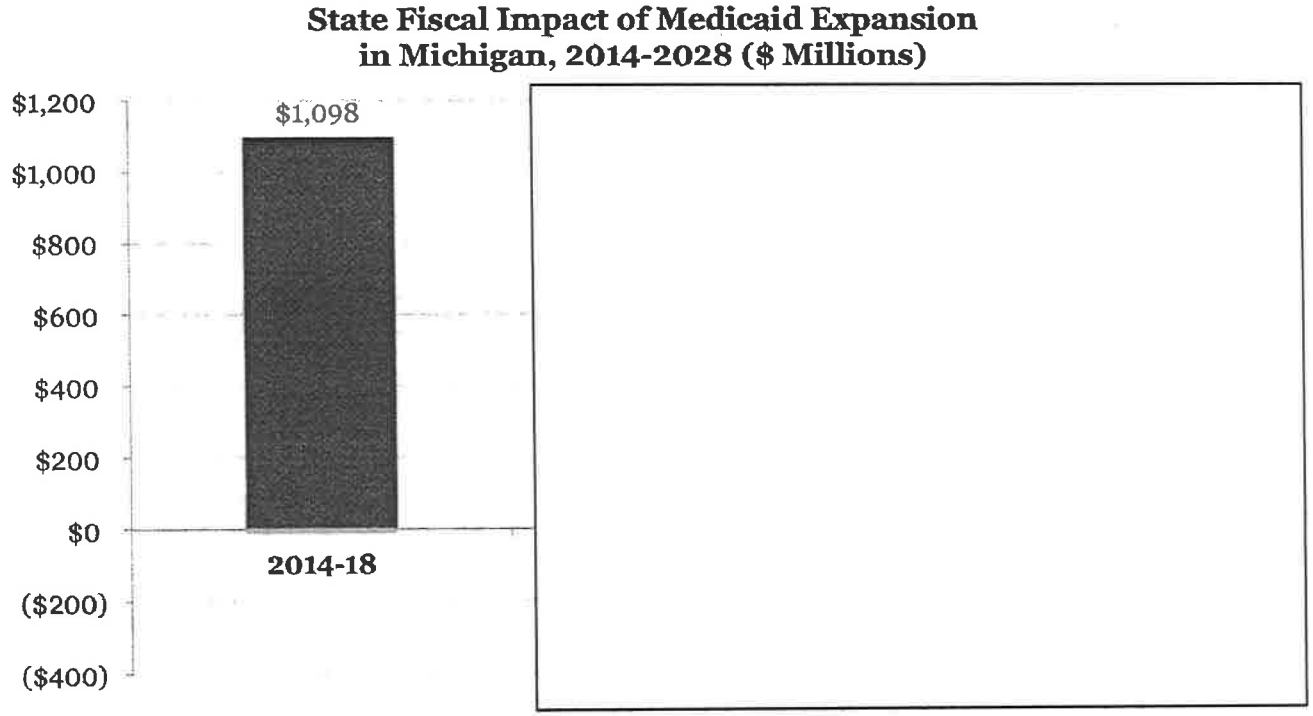
Share of Michigan Adjusted Gross Spending, FY 2014 ($50.9 Billion)



The Medicaid Expansion Bait-and-Switch

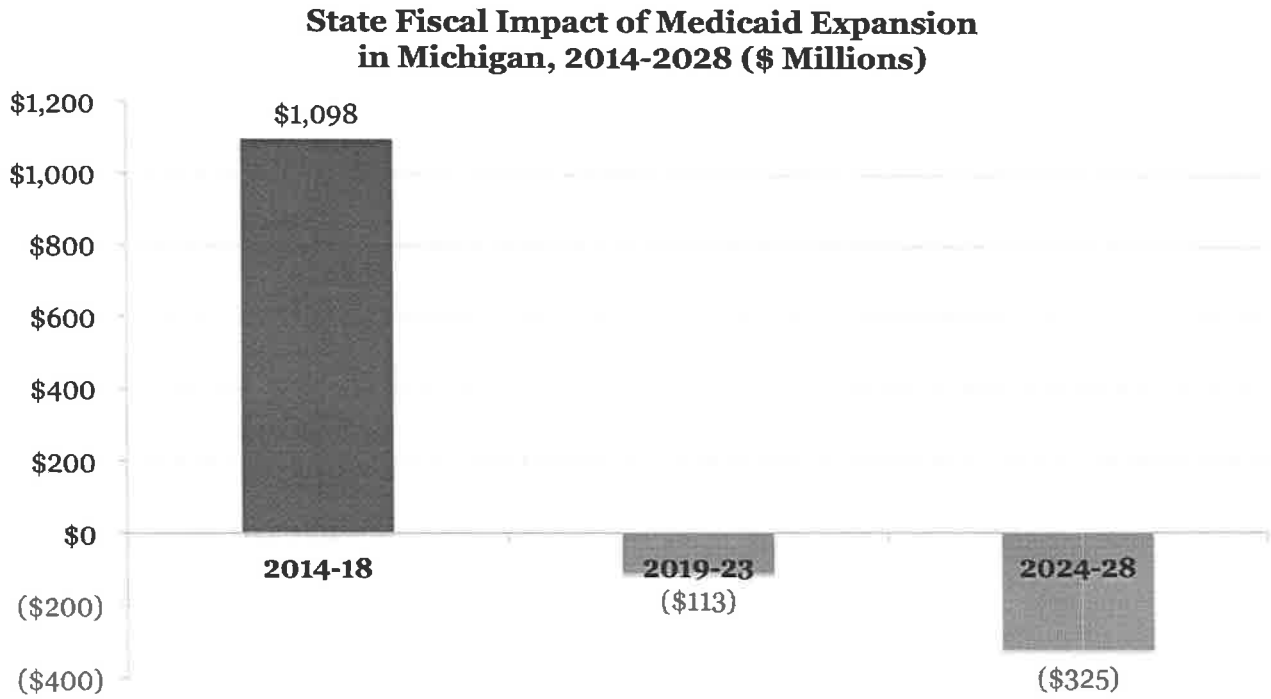
- Obamacare's expansion of Medicaid is primarily funded by the federal government...for now
- Federal taxpayers cover 100% of the costs in 2014, 2015, and 2016
- Federal match is 95% in 2017, 94% in 2018, and 93% in 2019
- Federal match declines to 90% in 2020 and thereafter
- **Congress is likely to further reduce matching rates as fiscal pressures increase**

The Medicaid Expansion Bait-and-Switch



- Expanding Medicaid yields a short-term windfall
- Primarily driven by high federal matching rate, and reduction in non-Medicaid mental health spending

The Medicaid Expansion Bait-and-Switch

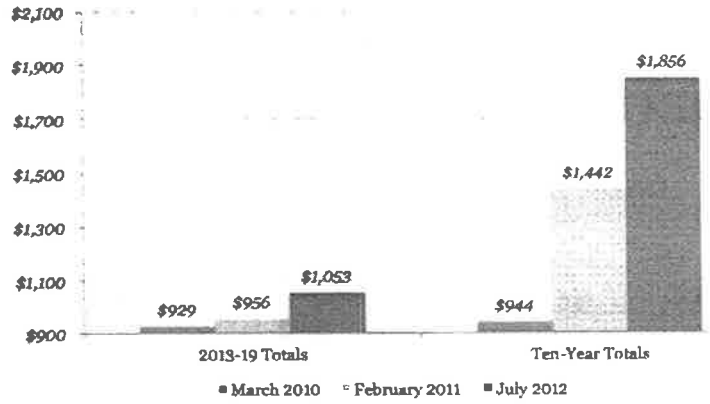


- Michigan starts losing money on the expansion in 2020
- Deficit spending worsens over time, even if federal matching rate remains at 90% in perpetuity

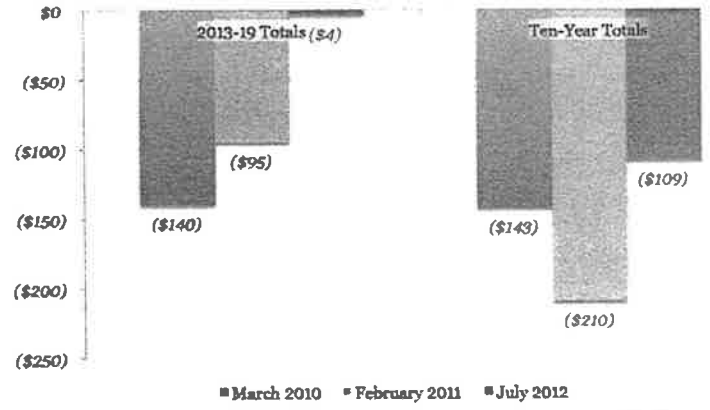
Bean Counters Aren't Omniscient

- While the CBO projects that the ACA is deficit neutral, gov't forecasts often underestimate spending and overestimate tax revenue
  - In 1965, Congress estimated that real Medicare spending in 1990 would be $12 billion
  - Actual 1990 spending was $110 billion
  - 2020 projected spending (CMS) is $1,047 billion
  - CBO only scores 10-year window

CBO Projections of New Spending Provisions in PPACA, 2013-2019 and Ten-Year Totals

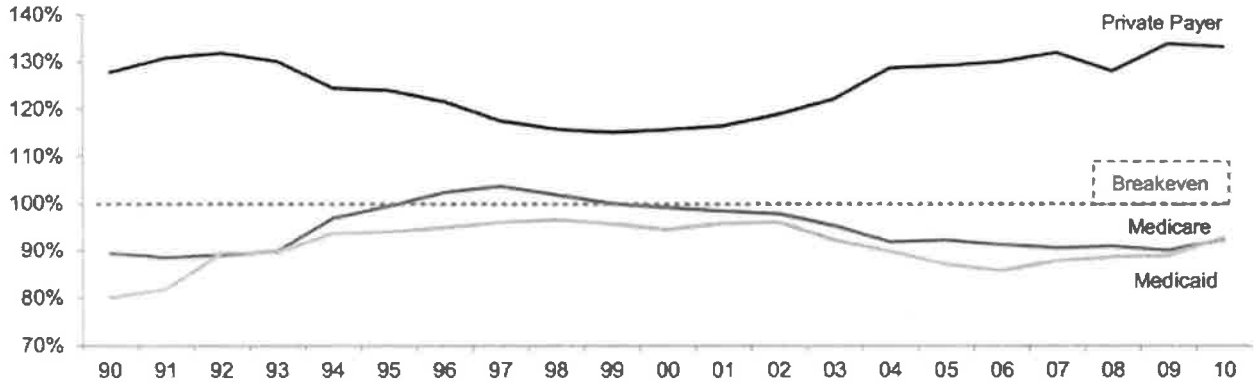


CBO Projections of Net Deficit Impact of PPACA, 2013-2019 and Ten-Year Totals

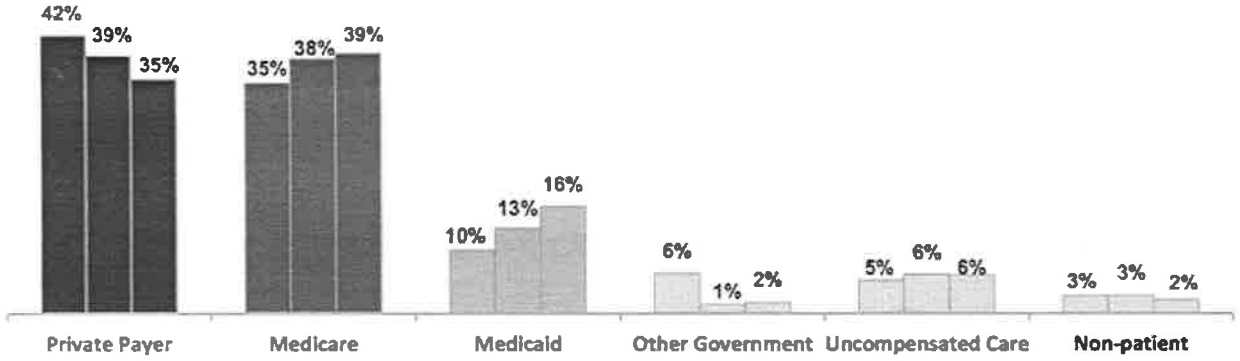


Medicaid Increases Private Premiums

Aggregate Hospital Payment-to-cost Ratios



Distribution of Hospital Cost by Payer Type (% of Total Cost) - 1980 / 1990 / 2010



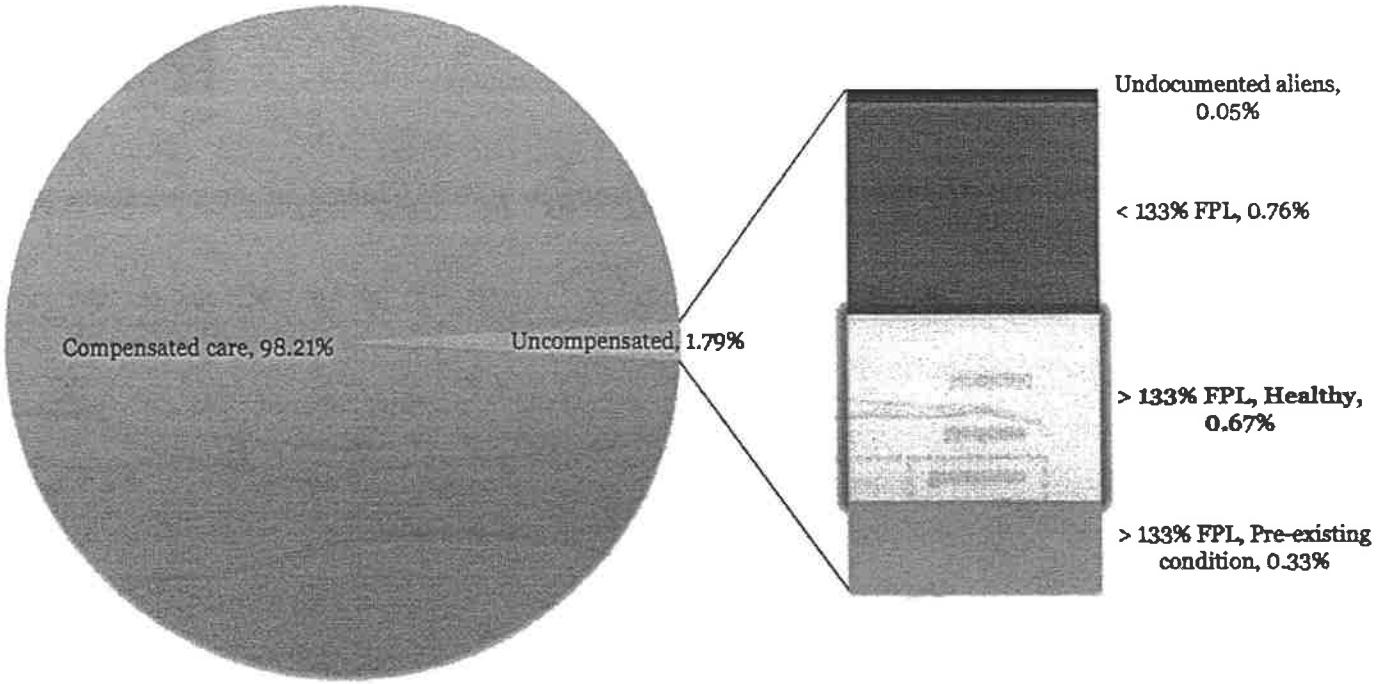
Source: Avalere Health analysis of American Hospital Association Annual Survey data, 2010

- Fee pressure from gov't payors leads providers to shift costs onto those with private insurance
- Role of gov't insurers will increase further with Medicaid expansion

The Myth of Uncompensated Care

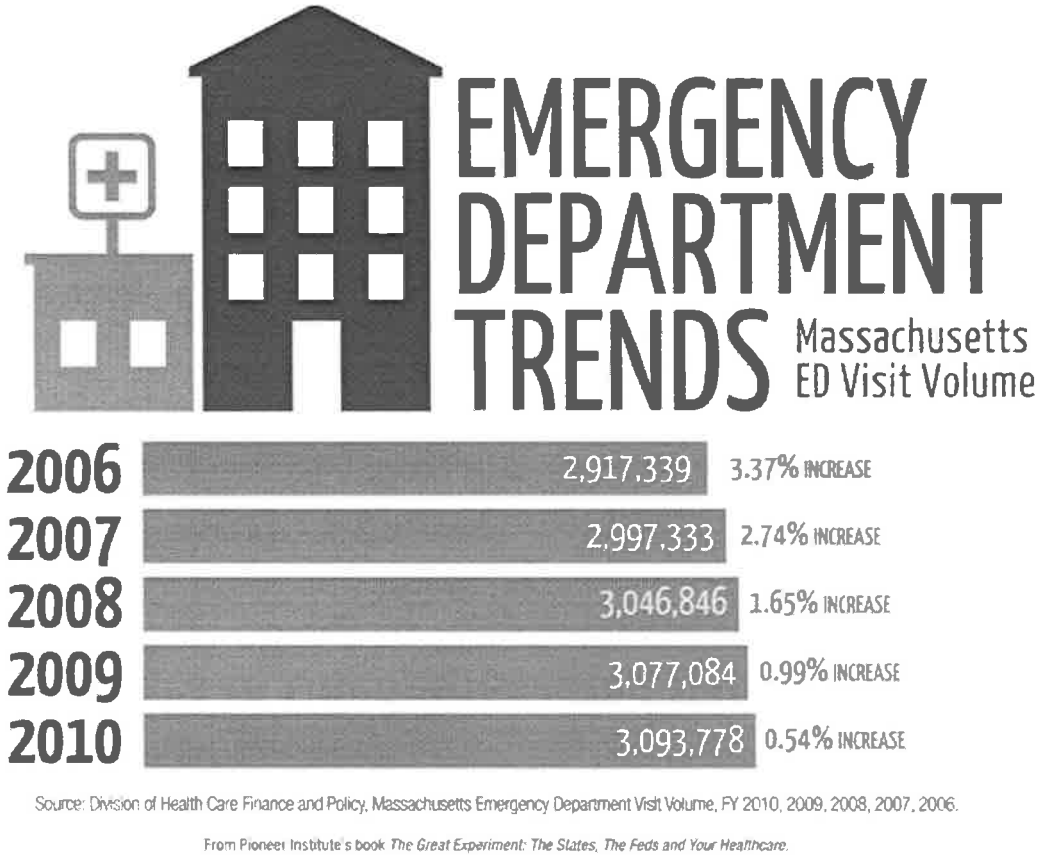
- "Free riders" are not a significant problem

Uncompensated Care As a Fraction of National Health Expenditures



Lessons from Massachusetts: Cost Increases

- Emergency room utilization went *up*; costs *increased*



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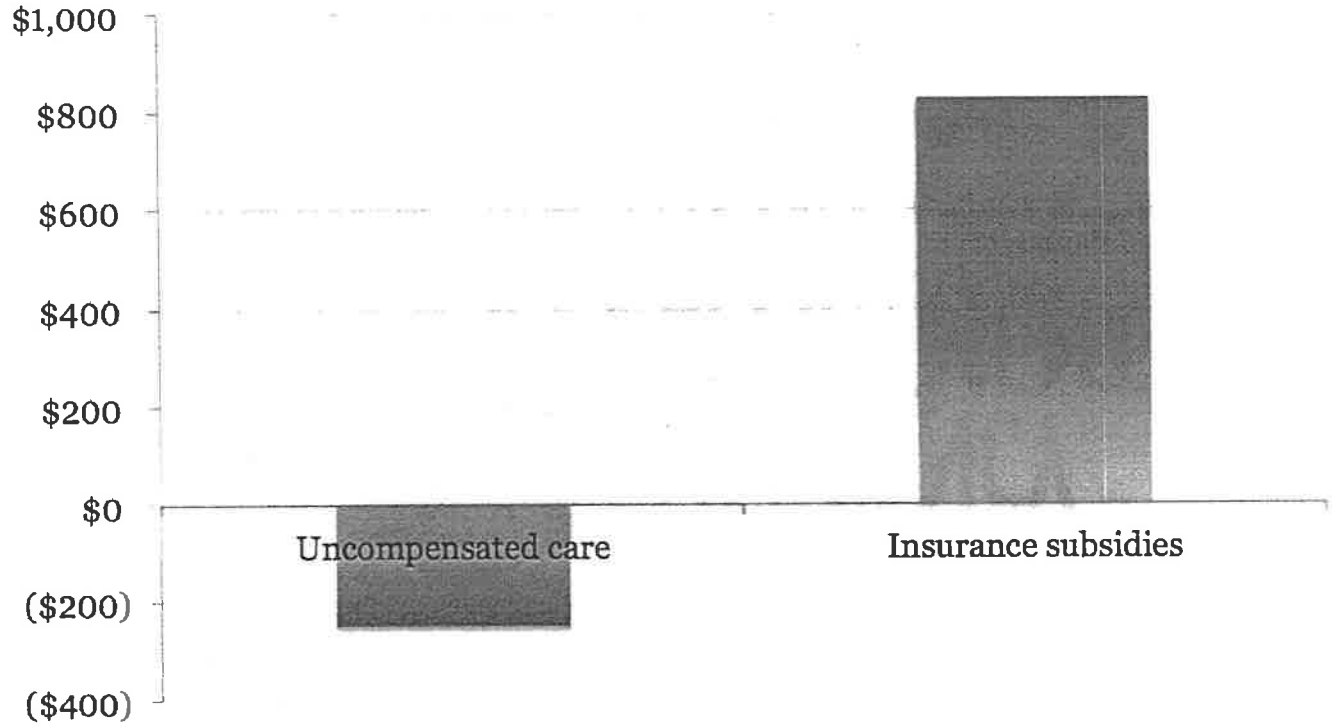
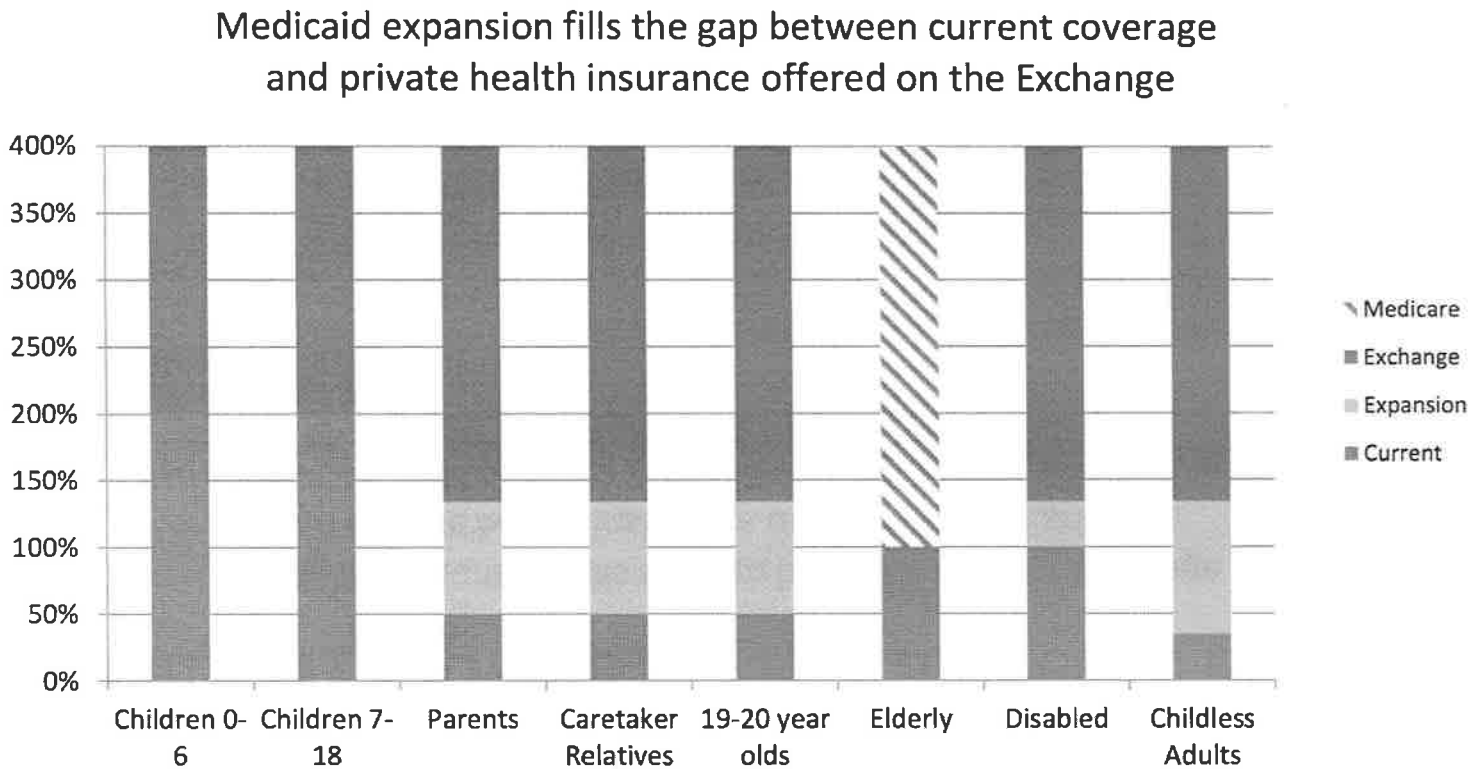
Changes in Uncompensated Care and Health Care Spending in Massachusetts, 2006-2011



Alternatives to Expanding Medicaid

- If Medicaid is not expanded, a significant population (100-138% FPL) moves to exchanges



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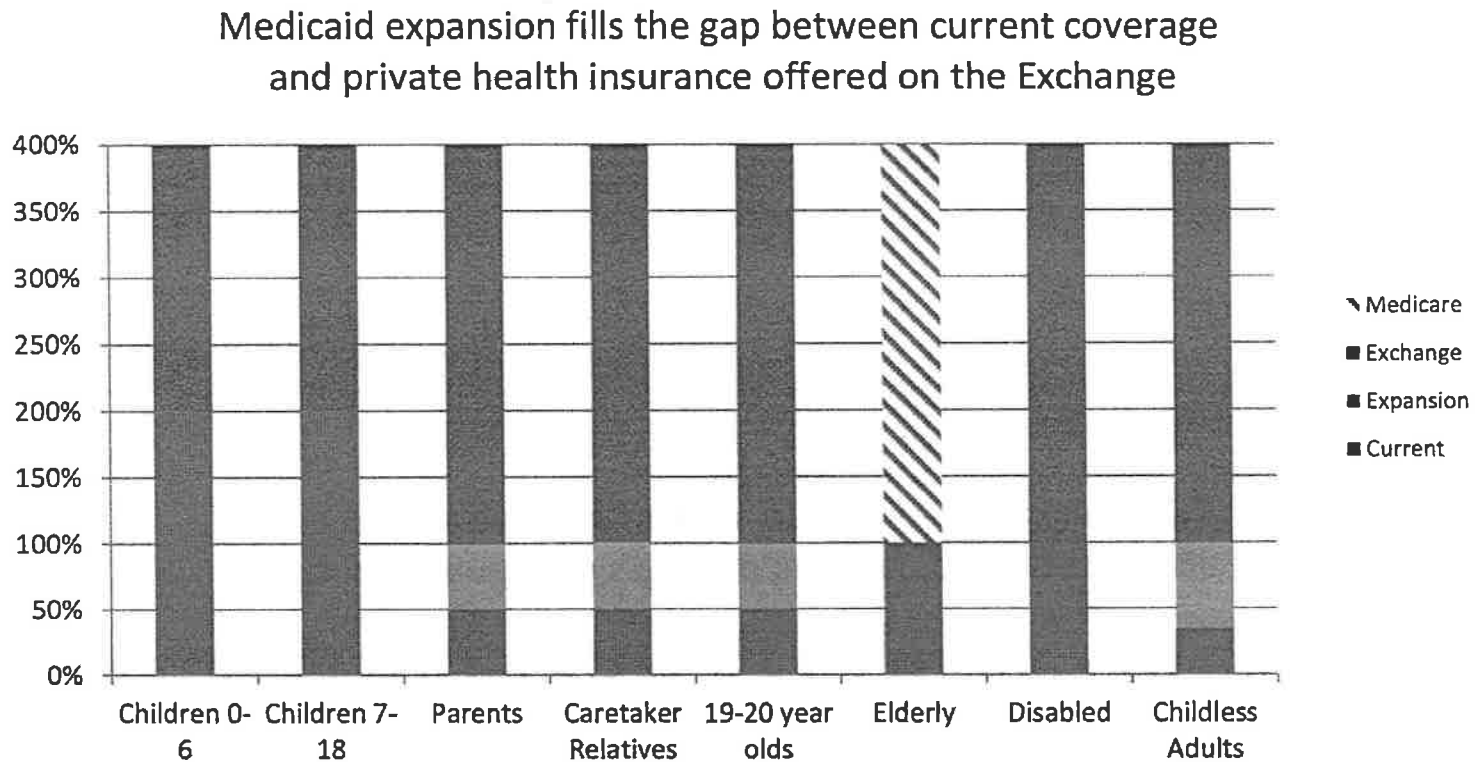


Alternatives to Expanding Medicaid

- Catastrophic coverage protects against serious financial risk, at the most cost-effective price
- Addresses uncompensated care problem, which is driven by free emergency-room care
- Can be combined with a health savings account to create a consumer-driven health plan
- HHS bars meaningful cost-sharing in the Medicaid program

Alternatives to Expanding Medicaid

- Indiana 2007 Medicaid expansion: combined high-deductible health plans with subsidized health savings accounts
  - 98 percent approval rate among plan enrollees
  - Iowa Gov. Branstad seeking to replicate Indiana
- Florida coverage expansion proposal: replace ACA Medicaid expansion with 100% state-funded catastrophic coverage & HSAs
  - Would cost Florida $237 million a year, vs. $1.3 billion a year for fully-implemented Medicaid

Deamonte Driver: The Face of Reform

- We can wipe out the budget deficit—and cover everyone—by harnessing market forces

The Moral Bankruptcy of Expanding Medicaid

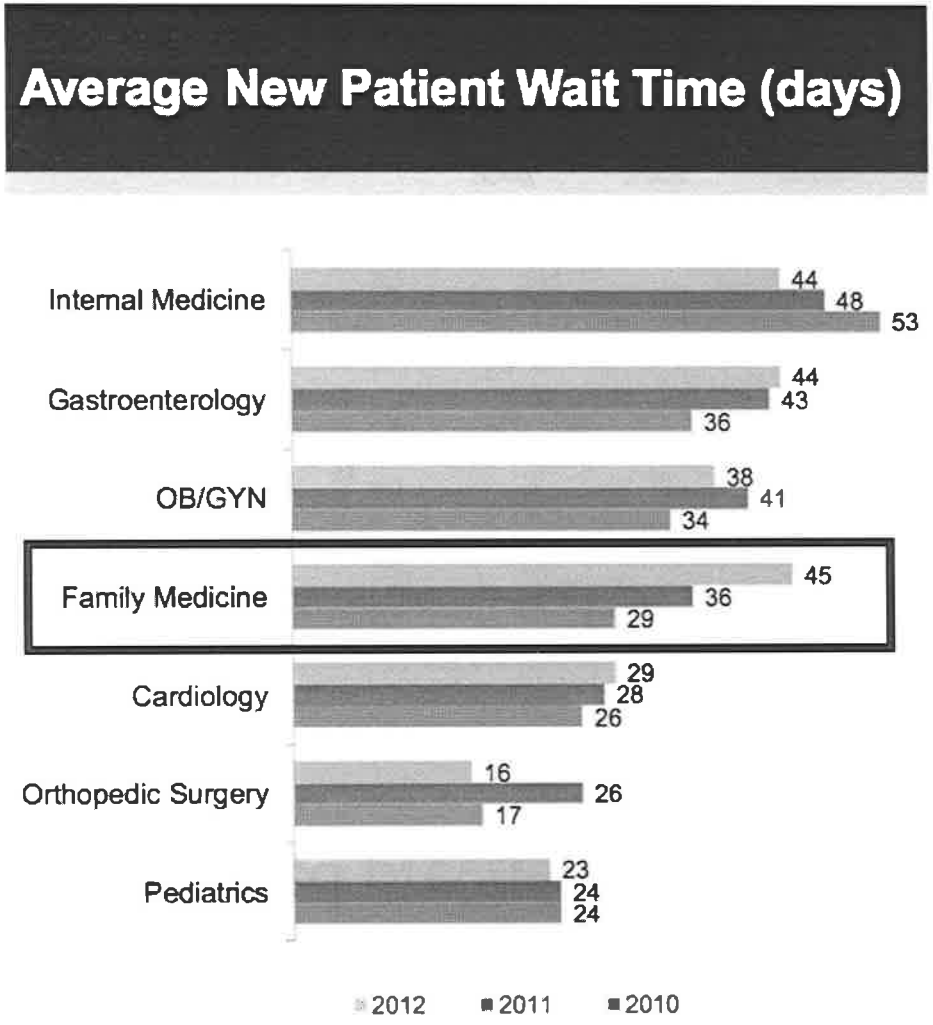
Avik Roy

Senior Fellow, Manhattan Institute for Policy Research

Email: avik.roy@aya.yale.edu • Twitter: @avik

Facebook.com/forbesaroy

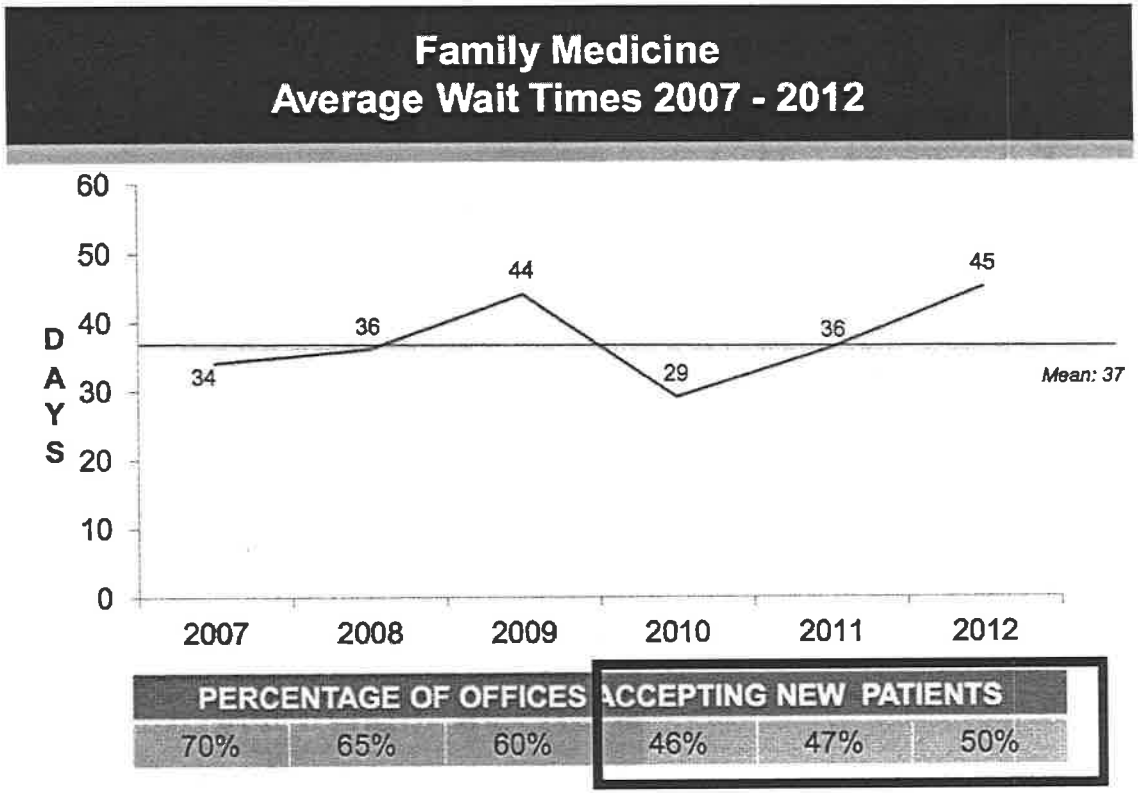
Lessons from Massachusetts: Patient Access



- Massachusetts achieved near-universal coverage after reforms enacted in 2006
- Massachusetts has some of the longest doctor appointment waiting times in the nation
- **Family medicine under heaviest pressure**

Lessons from Massachusetts: Patient Access

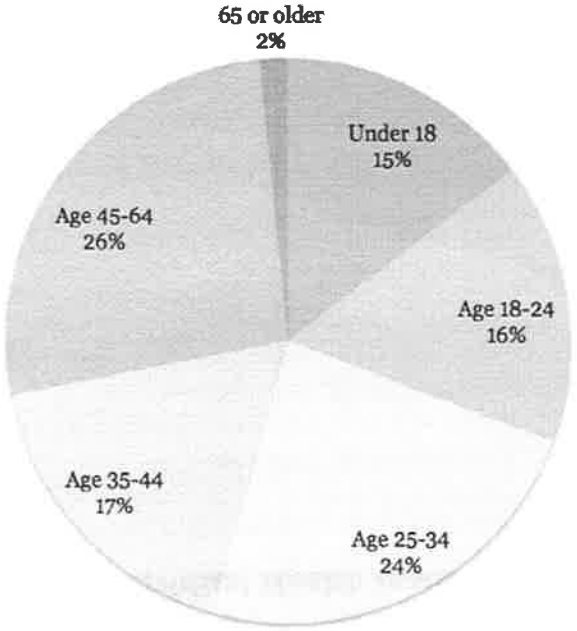
- In Massachusetts, acceptance of new patients has dropped precipitously



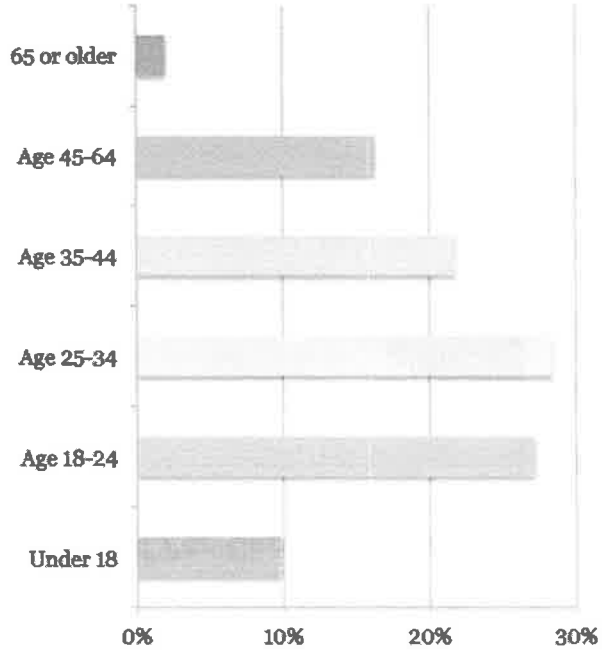
Who Are the Uninsured?

- The uninsured are primarily young and healthy...

Distribution of Uninsurance by Age, 2010

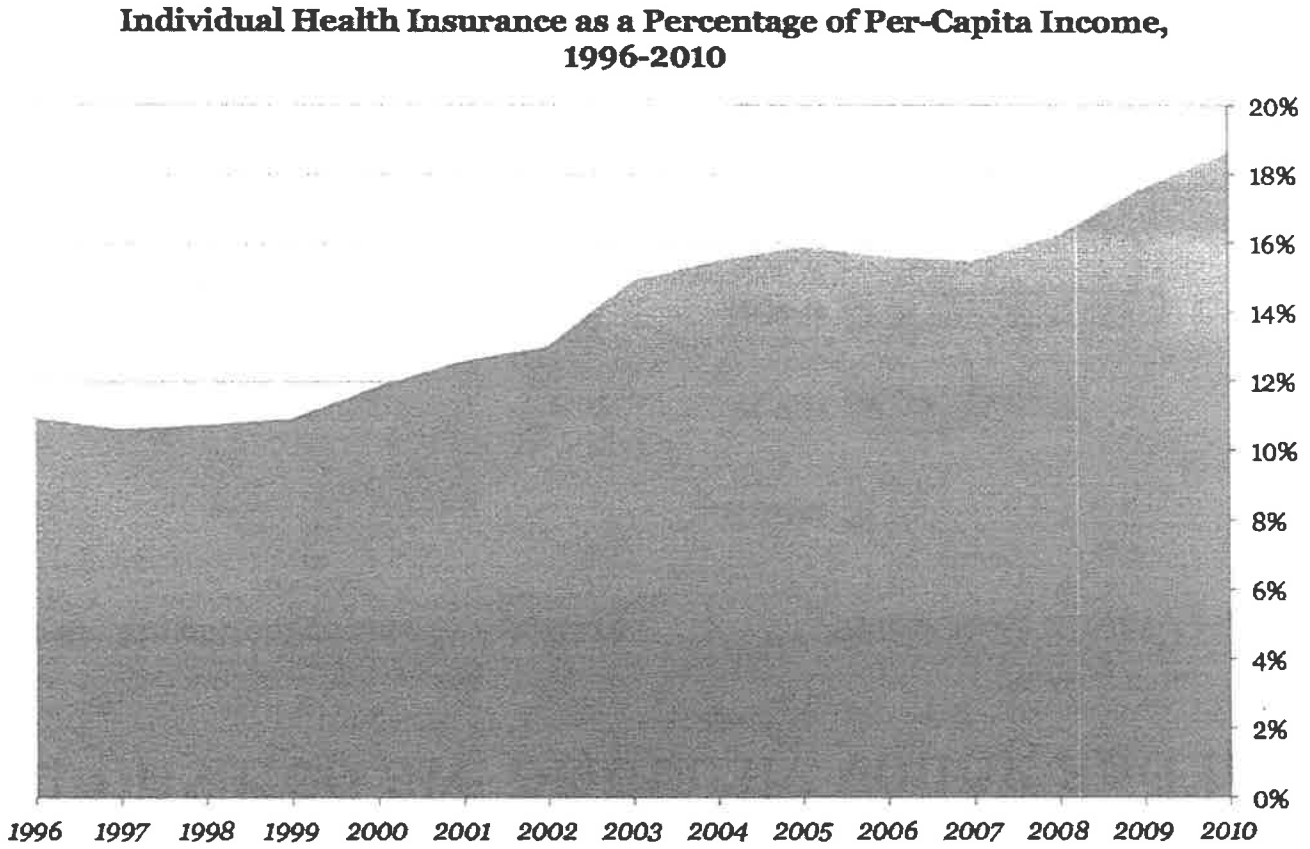


Uninsurance Rate by Age, 2010



Who Are the Uninsured?

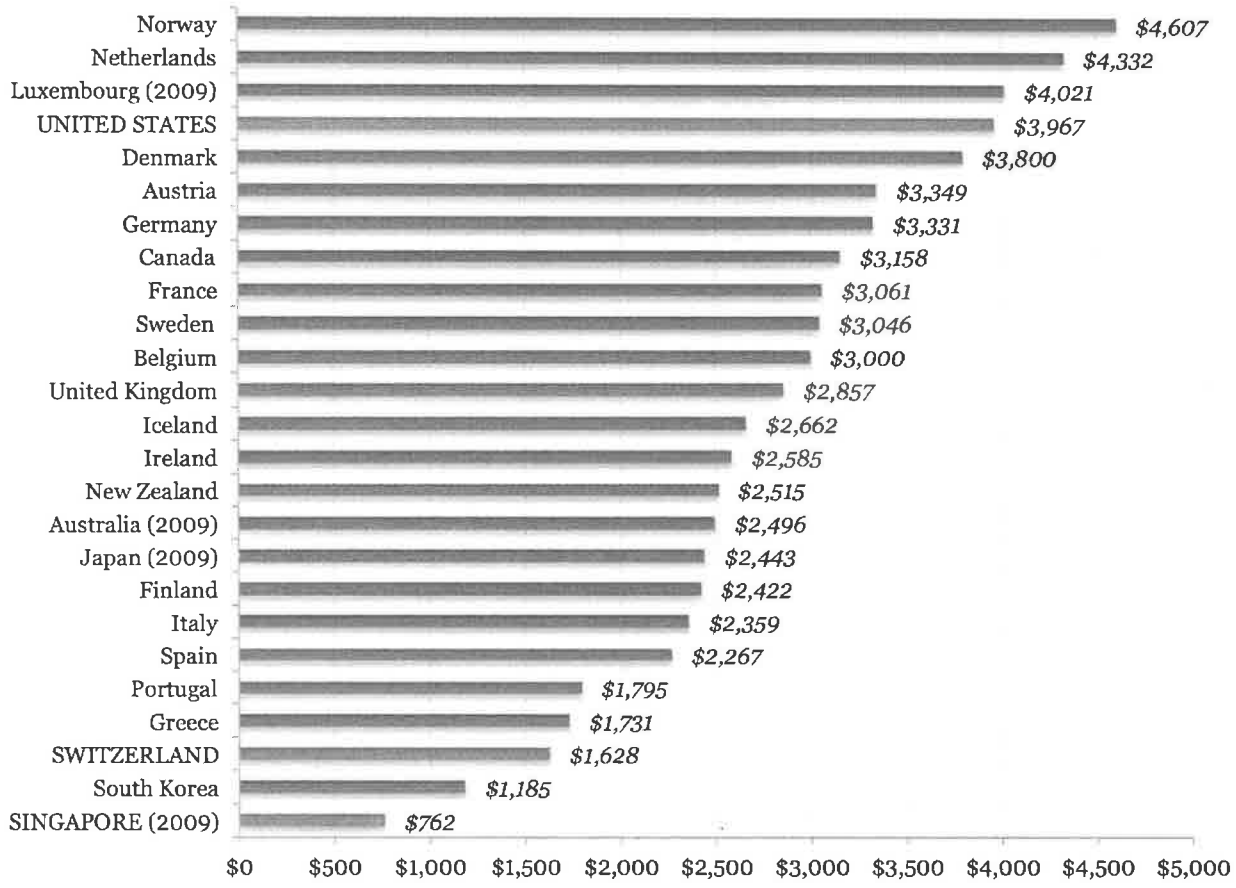
- ...But cost is a huge problem



The Myth of 'Free-Market' U.S. Health Care

2010 Public Health Expenditure per Capita
(US$ purchasing power parity-adjusted)

Source: OECD, WHO

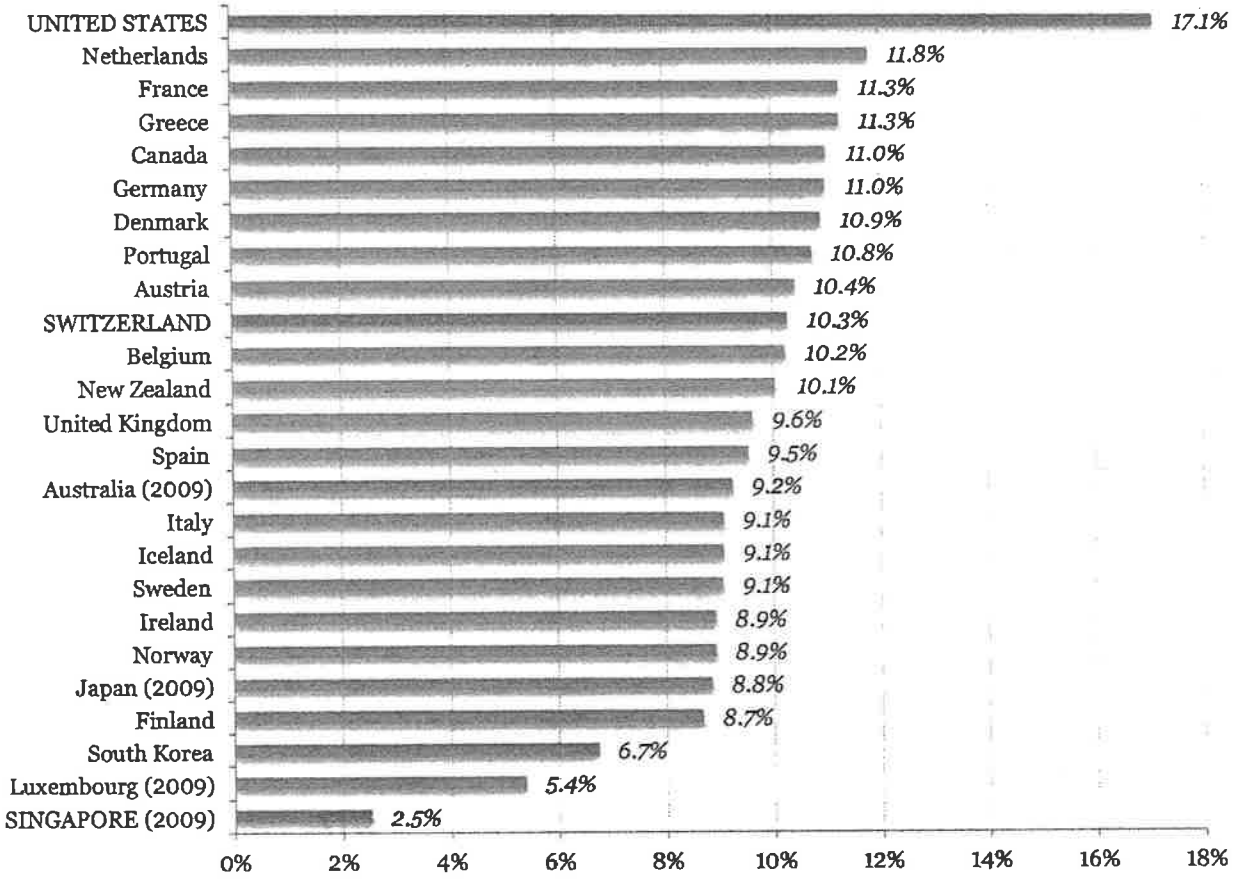


- In 2010, U.S. government (federal, state, local) **spent more per person on health care** than all but 3 other countries in the world
- Post-ACA, U.S will likely become #1

Real Market-Based Health Care Spends Less

2010 Health Expenditure as a % of GDP, Per Capita
(US$ purchasing power parity-adjusted)

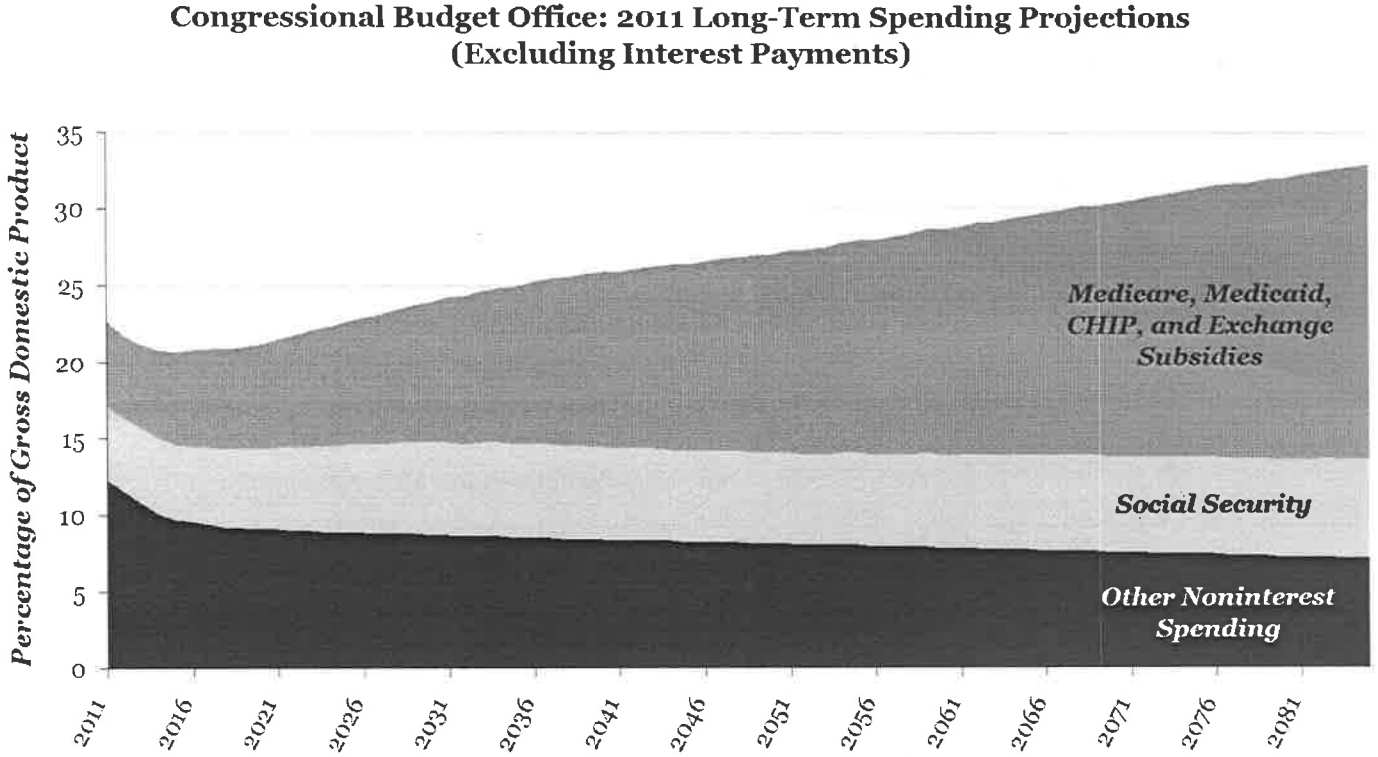
Source: OECD, WHO



- Singapore has a consumer-driven, HSA-based system of universal covg.
- Switzerland has a universal premium support system *a la* Paul Ryan, ACA exchanges
- **Market-oriented health systems perform well**

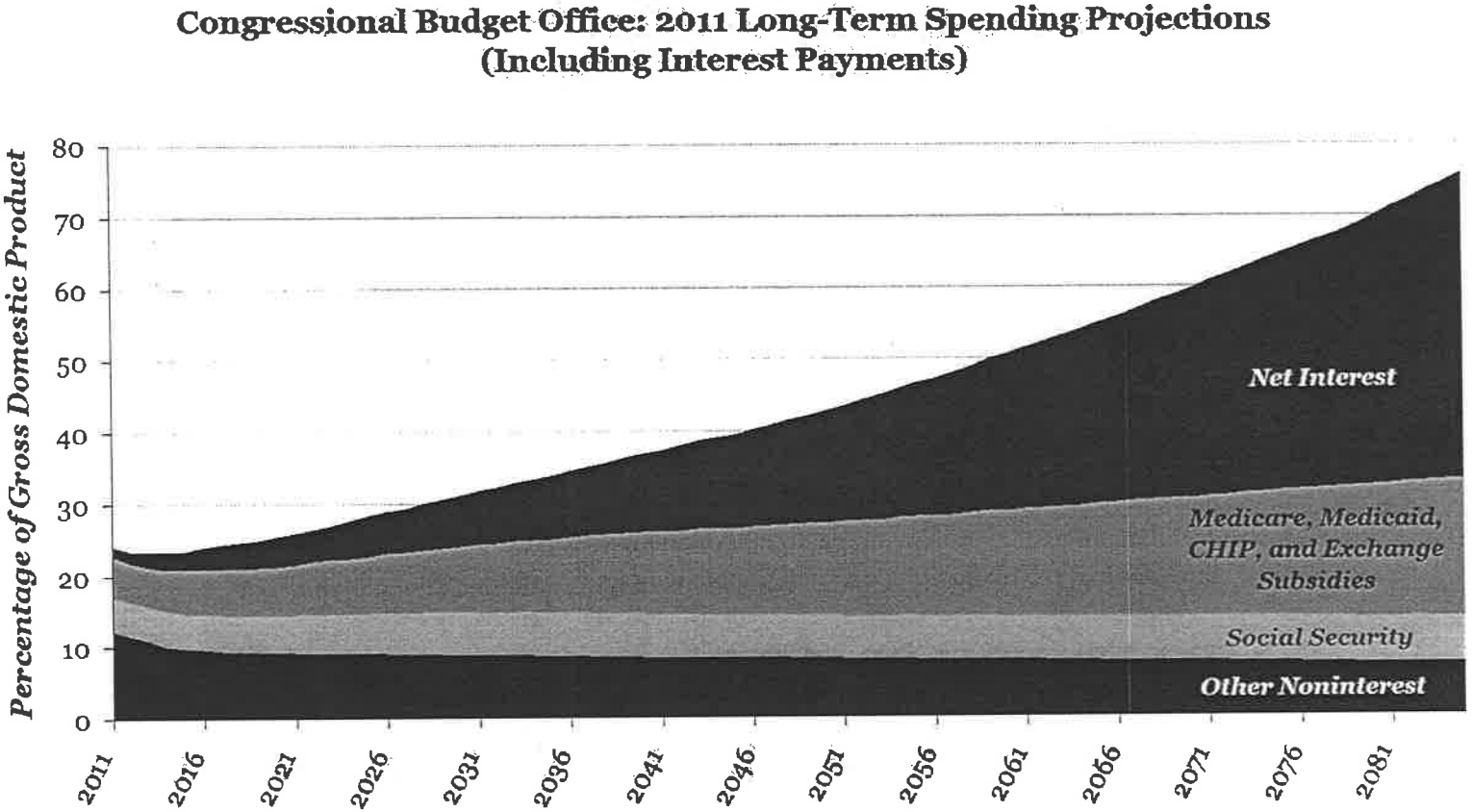
Half of U.S. Health Spending is Government

- The entirety of the growth of government spending as a share of GDP is health care...



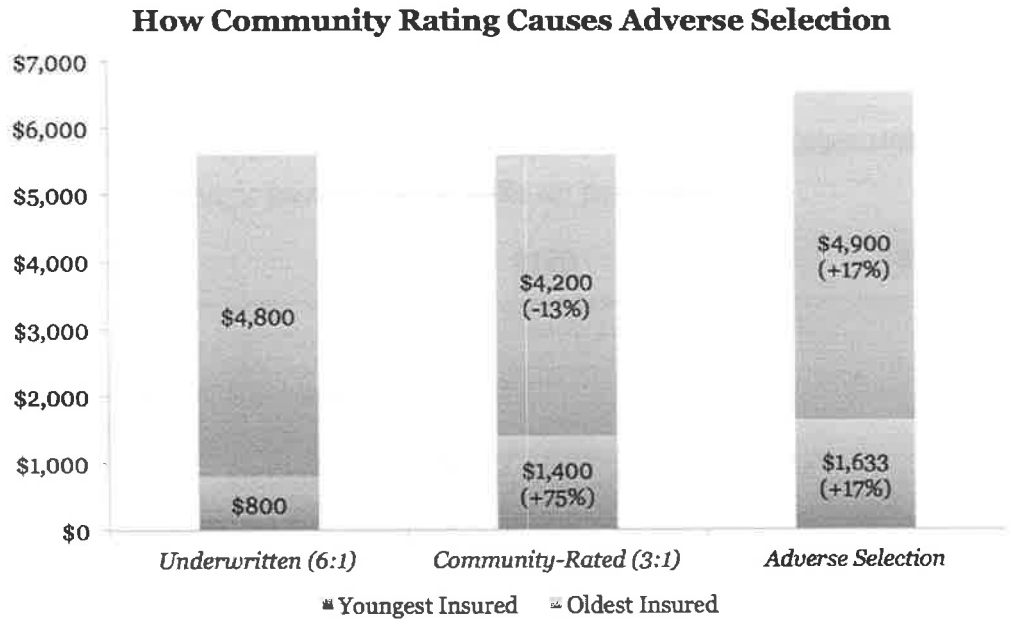
Half of U.S. Health Spending is Government

- ...If you don't count interest on the debt



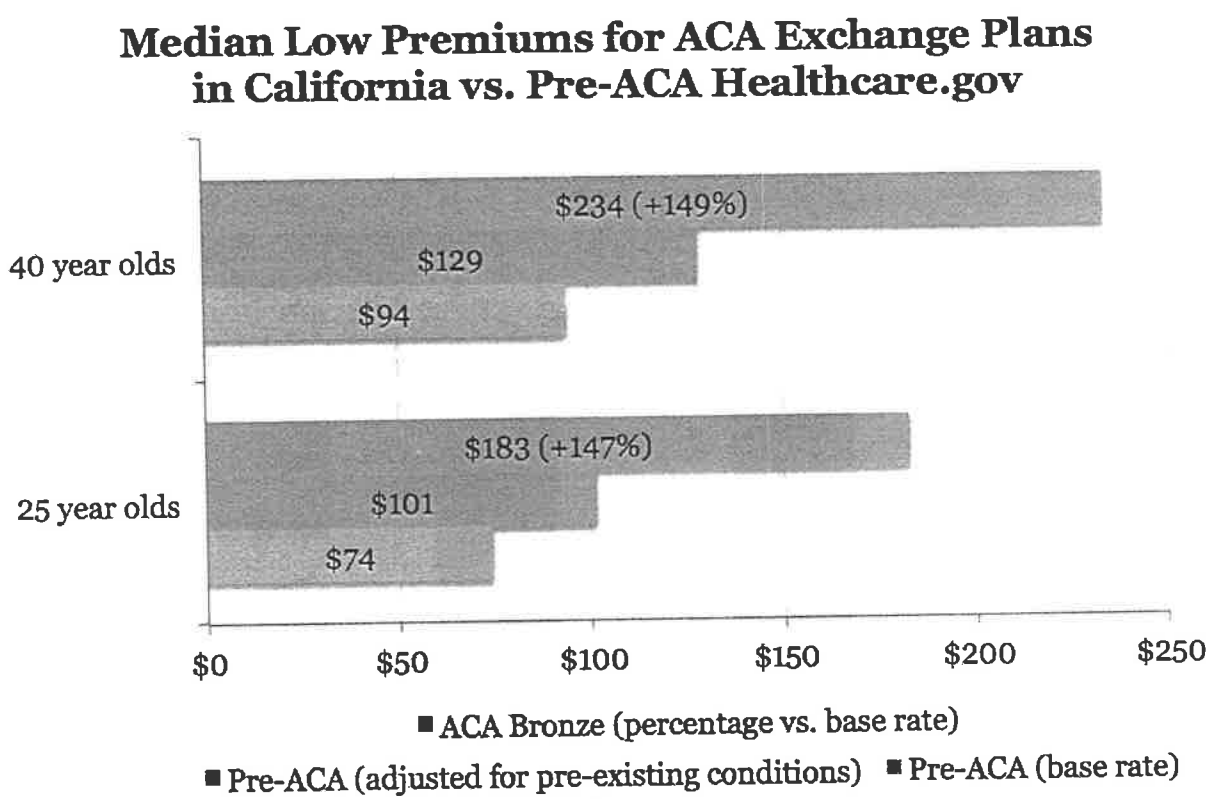
The ACA Makes Insurance Less Affordable

- Community rating will increase premium costs for the young, in order to subsidize the near-elderly
- The ACA's individual mandate is weak
  - For many, mandate fine ($695) much cheaper than insurance ($6,000)
- This will further encourage the young to drop out of the insurance market



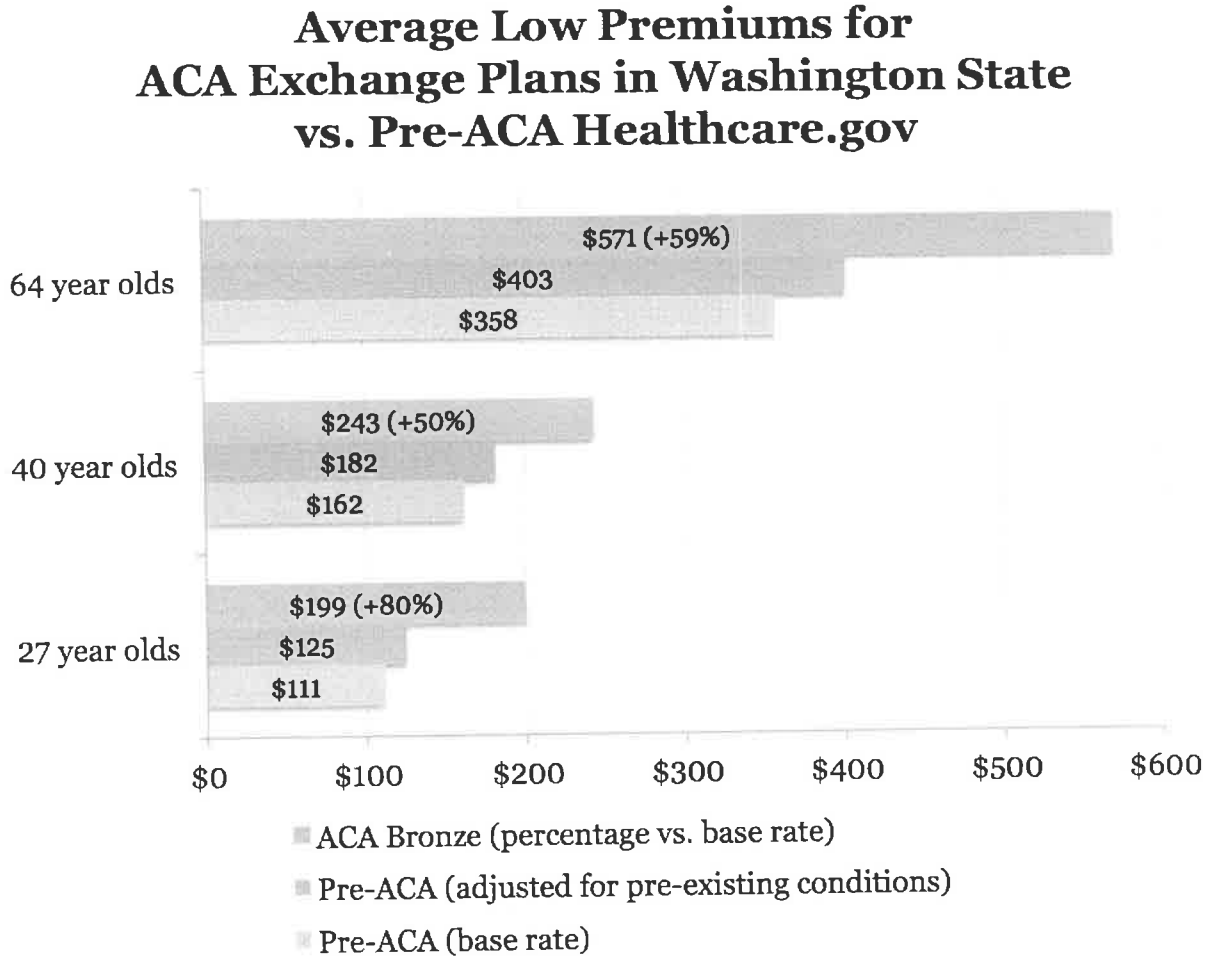
Rate Shock Highest In Less-Regulated States

- Rate shock will be greatest in states with lightly-regulated insurance markets, like California (+147-149% pre-subsidies)



Even High-Regulation States Face Hikes

- Rate shock will be less, but still significant, in states like Washington with heavily regulated insurance markets (+50-80% pre-subsidies)



CRAIN'S BUSINESS

Medicaid expansion counterproposal involves a 'free market' solution for Michigan patients

As a Senate workgroup prepares substitute language this week on the Medicaid expansion proposal favored by Gov. Rick Snyder, a counterproposal is in the works that doesn't involve government expansion, and instead offers a "free market solution" for patients across Michigan.

By Chris Gautz
July 23, 2013

As a Senate workgroup prepares substitute language this week on the Medicaid expansion proposal favored by Gov. Rick Snyder, a counterproposal is in the works that doesn't involve government expansion, and instead offers a "free market solution" for patients across Michigan.

That plan, authored by Sen. Patrick Colbeck, R-Canton Township, will be contained in two bills: SB 459 and a second bill still in draft form.

Combined, Colbeck said, they form what he calls a "patient-centered care solution."

SB 459 would create a regulatory environment to allow for a free market system by setting up a portal for private health care exchanges, he said.

The second bill would move the state's current Medicaid population into a qualified health plan that features direct primary care services and a high-deductible health plan wrapped within a health savings account.

"We are changing the method of delivery of health care services," Colbeck said of his plan.

The only roles government would have in the process would be to determine eligibility for assistance and provide the funding. No federal waivers would be needed, Colbeck said.

Colbeck presented his plan last week to the Senate workgroup that has been working over the summer on changes to HB 4714. He said the members seemed enthused about what they heard.

"I thought it was well-received," he said.

Colbeck's plan: Eligible adults would receive health care debit cards

HB 4714, which the House passed and the Senate did not vote on before leaving for summer break, would expand Medicaid coverage to those up to 133 percent of the federal poverty level.

The workgroup is expected to present its findings to the Senate Government Operations Committee next week, Colbeck said.

Colbeck said he has been assured by Senate Majority Leader Randy Richardville, R-Monroe, that his plan will receive a hearing in that committee.

Colbeck said he is a firm "no" vote on HB 4714, regardless of any changes that might be made to it, so long as it is still an expansion of government assistance.

He said his plan is better because it takes government largely out of the equation, reduces costs and makes Michigan businesses more competitive with surrounding states that will have higher health care costs.

"I think it is a potential huge boon for our economy," Colbeck said.

Colbeck said the government is now spending, on average, $5,000 a year to provide care for a single adult on Medicaid, when the private sector could provide better coverage much cheaper. Under his plan, the government would determine whether a person is eligible for assistance in purchasing his or her own commercial health care coverage; if eligible, he or she would receive a coupon for $2,100. This coupon, in the form of a health care debit card, would help cover the monthly cost of a high-deductible plan for catastrophic coverage, as well as the monthly fees for a direct primary care service.

That $2,100 figure, he said, is based on current rates in Michigan, as well as what is offered by other states.

Those between 100 percent and 133 percent of the federal poverty limit, who would receive access to Medicaid under the expansion plan passed by the House, would not see any expansion of coverage under Colbeck's plan.

But these estimated 450,000 people would be able to more easily afford private health care coverage, because his plan would help lower insurance costs overall, Colbeck said.

"Rather than talking about expanding access to Medicaid, we're starting to talk about expanding access to quality care," he said.

Feedback on the plan

Colbeck's plan is one of three regarding Medicaid that the Government Operations Committee is expected to consider. Others include a new version of HB 4714 the workgroup has crafted, and a plan by Sen. Bruce Caswell, R-Hillsdale, that would create a low-income health care trust fund.

Charlie Owens, state director of the National Federation of Independent Businesses-Michigan, opposes HB 4714 and said he is familiar with the concept behind Colbeck's plan. He said he thinks it could gain traction.

"As a concept, these are things our organization has supported for many years," Owens said.

He said some of the small businesses in the state that belong to his organization would likely look at ending the current coverage they offer to their workers and move to something like this.

"For those that are providing health insurance, this would probably be a more cost-effective approach to what they are doing now," Owens said.

But Colbeck's bills provide challenges both technically, in terms of making sure it would fit inside the guidelines of the federal Patient Protection and Affordable Care Act, and also politically.

"You just have so many parties wedded to the status quo," Owens said. "Politically, it's easy to be dismissive of it, and too often in politics, easy is what is done."

Rick Murdock, executive director of the Michigan Association of Health Plans, said he is aware of the concept in Colbeck's bills, and has some concerns, but still wants to learn more once they are introduced.

He said it is unclear if it would work as Colbeck envisions, and said it also doesn't seem to address the reforms to the Medicaid system that were contained in HB 4714.

Murdock said his members have spent a considerable amount of time, energy and resources planning for changes to Medicaid and health coverage under the state-federal partnership health exchange. "Our members have to address what is in front of them. This legislation would do something completely different," Murdock said. "I don't know how to deal with that at the moment."

Murdock said his organization supports HB 4714 and has been working with the Senate workgroup on the changes it is making to the bill.

"We believe that's the way to go," Murdock said.

Forbes

Dave Chase, Contributor
I power/cover disruptive innovators reinventing healthcare.

PHARMA & HEALTHCARE | 7/29/2013 @ 10:23AM | 534 views

Michigan's Financial Crisis Demands Major Healthcare Surgery

Not a week goes by without seeing some headline about deficits pushing municipalities to desperation or Bill Gates describing state budgets using accounting techniques that would make Enron blush. Detroit is the most visible recent example. The common culprit: healthcare costs with Medicaid being the biggest driver.

While Michigan governor Rick Snyder considers Medicaid expansion, he has a choice. Follow tried and failed solutions that are minor variants on what has put governments into great financial duress or scale up proven models that have emerged as part of the DIY Health Reform movement. In my study of innovative care models, nothing has impressed me more than the Direct Primary Care (DPC) models which I wrote about in a previous Forbes series. Reducing the most expensive facets of healthcare while getting customer satisfaction ratings higher than Google or Apple will make any governor take notice.

Making minor tweaks is no longer an option for Michigan. Fortunately, Michigan is also well-positioned as it has been a leader in adoption a care model called Patient Centered Medical Homes (PCMH). While the PCMH is a big step towards reinvigorating a healthy primary care model, those who critique PCMH state that they are "putting wings on cars and calling them airplanes." The critics point out that the precepts of PCMH are solid, however they are layering some additional fees and services on top of a fundamentally flawed fee-for-service (FFS) model. Primary care doctors describe the FFS model creating a hamster wheel model of 7 minute drive-by appointments. Those providers financially optimizing FFS recognize that having primary care as the "milk in the back of the store" (i.e., low margin offering designed to get people to the high margin offerings) is the way to optimize profits. Thus, a transition from PCMH to DPC is a logical next step. A key side benefit is removing insurance bureaucracy for primary care doctors since that is the #1 reason primary care doctors are leaving medicine. In light of the well-documented primary care shortage, we can't afford to lose more than we've already lost.

Bipartisan Solutions Awaits Michigan

Fortunately, there is a solution that has bipartisan support and has shown to reduce utilization by 40-80% (e.g., Seattle-based Qliance) and overall costs 20

-30%. It can be described as two parts Marcus Welby and one part Steve Jobs. The federal health reform bill included a little-noticed clause allowing for Direct Primary Care (DPC) models to be a part of the state health insurance exchanges. That little-noticed clause (Section 1301 (a)(3) of the Affordable Care Act and proposed HR3315 to expand DPC to Medicare recipients) should have the effect of massively spreading the DPC model throughout the country. Despite DPC getting notice initially in a Democratic administration, the author of HR3315 is a vocal Obamacare detractor (Rep. Bill Cassidy, R-Louisiana) and a Michigan state Republican representative, Pat Colbeck, has proposed DPC legislation to the Michigan legislature.

> "The future is already here — it's just not very evenly distributed. – William Gibson

A common myth is DPC is the same or similar to their more expensive cousin — concierge medicine. Not so. Typically one-third of DPC practices are uninsured people. The latest example of DPC serving low income populations was highlighted in Nobel Prize Winner Sets Sights on Fixing U.S. Healthcare.

[Contact me via LinkedIn if you'd like a copy of the seminal study on the Direct Primary Care model that is part of Obamacare.]

Let's break down how it's possible to provide such a high level of service at such an affordable price (i.e., less than a typical cable bill). It's simple: low overhead. It's not unusual for a primary care practice to have 3-5 administrative staff for every doctor. This is necessary to deal with the myriad insurance billing schemes that can best be described as a Gordian Knot designed by Rube Goldberg. Smart utilization of affordable technology (often in the low hundreds of dollars per month vs. many thousands and ongoing headaches) is at the heart of it. This allows the doctor to practice medicine the way they were trained, rather than pulling their hair out dealing with insurance for the medical equivalent of a trip to Jiffy Lube. In other words, the practices run similar to the fabled Marcus Welby, MD days. Yet, they are improved upon with a dose of Steve Jobs enabling enhancements that weren't possible in the past such as virtual house calls. In anticipation of the rapid expansion of these models, entrepreneurs such as BJ Lawson, MD of Physician Care Direct have developed software to run the business side of these practices. *[See more on how practices are overcoming obstacles to switching to Direct Primary Care.]*

Care Model Reduces Overall Healthcare Costs by 20%

Thus far, DPC has had success in the private market though I recently heard of reports of it being used to serve Medicaid recipients in Washington state. I put the question of why not use DPC for the Medicaid population to DPC practitioners. The response below is a summary of their perspective. It is estimated that **if DPC was scaled nationally it could save 20-30% off of overall healthcare costs**. That would be the difference between states defaulting and sustained balanced budgets.

> "The issue of using DPC for the poor is from my point of view a no brainer. Why use the most expensive inflationary system available (by which I mean the insurance system, whether public or private) to take care of those with the least money and most in need of basic services? The structure that makes sense to me is to create a thriving marketplace in direct primary care, competing on price, access and quality – and working exclusively for our patients. Then add a fixed monthly stipend for primary care for every Medicaid patient in the United States – a stipend that covers the lowest priced/highest functioning primary care available. This could be a voucher or credit card account for each Medicaid patient. The allowance could only be spent on primary care and the patients could buy up to higher priced practices if they saw value worth purchasing. That would convert the Medicaid

patient from being a low paying, high utilizing patient to a valued customer who can pay cash for care at a reasonable price. This makes all kinds of sense economically:

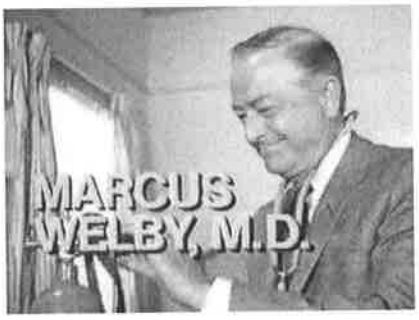
1. No government management system to control or manage care – it manages itself with the patient at the helm.
2. Converting dependent impoverished citizens into patients with economic clout and respectful treatment
3. Eliminating the cost overhead of insurance billing on both the MD and the government side
4. No more barriers to basic care for Medicaid patients – they can use all they need
5. Eliminating the fee-for-service incentive disaster that produces massive overutilization and huge downstream expenses
6. Financially stabilizing the primary care world with consistent monthly fee payments to cover our fixed costs while allowing those docs with better ideas or higher prices to go for the upscale patients or those wanting better art work and longer visits.
7. Free up primary care docs to further improve their quality, access and patient centered services – not their billing savvy.
8. If the government wanted to regulate, they could demand an annual report on each patient they support, giving the actual utilization, health care outcomes and proof of appropriate management of common illnesses, immunizations and cancer screening. The government could actually pay for results, not process. Primary care practices would have to be certified as producing an acceptable level of results and patients would have access to our success profiles both in terms of cost and quality when selecting their doc for next year.
9. The government could track the overall costs created by each practice and make those numbers public as well. The high cost practices would eventually lose certification, particularly if the money ended up in the hands of their employer (hospitals, big multi-specialty clinics).
10. If the government wants to tackle the HotSpotters patients (something Iora Health, whose founder was featured in that article, has already done), they just need to up the monthly ante for the sickest patients – they will get their money back with huge interest from the reduced downstream costs and reduced transaction costs that these folks generate. With the big fees they will also be able to require more complete reporting of how their chronic illnesses are being managed.

Medicare should do the same – stop paying fee-for-service for Primary Care and start paying a fixed monthly fee (allowing patients to buy up if the government gets the price wrong, as it almost certainly would). The patient should have total control over which primary care doc gets the money – remember, we want to work for the patient, no matter who pays the bill.

So that's the solution – a simple system where the patient is in charge, the government buys good basic care and the patients can buy up. The system itself is created within a free market structure which the government is simply choosing to ride (like food stamps and grocery stores) with patients running the show, so service and quality could go up every year while prices remain stable or decline – like any real functioning market system in the world. Direct Primary Care is the only available model that could accomplish these goals. Everyone else is still trying to figure out how to "work" the insurance system. However, if the government has wisdom, they would also make the monthly fee deal available to prior fee-for-service docs – to boost competition and to accelerate the conversion to Direct Primary Care models. The right incentives produce the right results. Pioneering doctors such as Dr. Garrison Bliss and Rushika Fernandopulle have the results they are happy to share with any political or business leader recognizing our healthcare system needs radical surgery, rather than minor tweaks.

Recommended reading: Cracking Health Costs is a blog and a book. Though the authors weren't aware of Direct Primary Care when they wrote the book, they have many useful ideas if one wants to tackle the cost crisis at an organization level.

This article is available online at:



Marcus Welby, M.D. (Photo credit: Wikipedia)

http://www.forbes.com/sites/davechase/2013/07/29/michigans-financial-crisis-demands-major-healthcare-surgery/

The Detroit News
Jul 26, 2013
Michigan Medicaid reform: Health savings accounts
By Gary Wolfram

Several years ago in the Michigan Chamber of Commerce's magazine, I suggested that the state move its Medicaid program to the equivalent of a health savings account. The private sector had already begun this transition as a market response to climbing health care costs.Now Senator Patrick Colbeck has proposed the idea in response to Obamacare's mandates.

There are a number of reasons Senator Olbeck's proposal would improve health care for Medicaid recipients, reduce health care costs for all Michigan citizens, and save taxpayers money. It all comes down to restructuring the incentives of the system and removing the unintended consequences of Medicaid.

When discussing the basic economics of people responding to incentives, I ask my Hillsdale students the following question: "When do you tell someone that you are picking up the tab for dinner?" After they have ordered, comes the answer. People will spend their own money in a more frugal fashion and pay more attention to prices.

The fundamental problem with U.S. health care is third-party payment. Someone else is picking up the tab and the consumer already knows this. In fact, in my story about dinner, the waiter knows this. So we have the equivalent of the waiter bringing out the $100 bottle of wine.

The problem of improper incentives lies on both the demand side and the supply side. Consumers of health care don't ask about price, and suppliers have an incentive to produce expensive health care services that may not improve your health very much. These incentives lead to very expensive treatments. The government insurance company, Medicaid, then sets limits on how much it will pay for services. Doctors then stop taking Medicaid patients. The patients end up using expensive emergency rooms for minor illnesses, and the cycle continues with high taxpayer costs and poor quality of service for Medicaid recipients.

Senator Colbeck's proposal to turn Medicaid into a a health savings account with a high deductible catastrophic care policy would move incentives in the correct direction. Those on Medicaid would be able to keep funds they didn't spend this period for later medical use and so would become sensitive to the price of services. Health care providers would respond by competing on both service and price, bringing down health care costs for all and reducing the tax burden of the state's Medicaid system.

Imagine Walgreen's, Rite-aid and other chains setting up nurse practitioners in their pharmacies, offering low cost medical services as well as prescription drugs. We may not know exactly how the market will respond, but we can be assured that it will in a way that will reduce costs and improve services – once the incentives have been changed.

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On Retainer:
Direct Primary Care Practices Bypass Insurance

California HealthCare Foundation

ISSUE BRIEF

Introduction

Direct primary care (DPC) is an emerging model for delivering medical care that has gained some attention in California and nationally in recent years. Sometimes referred to as "retainer practices," DPC practices generally do not accept health insurance, instead signing up patients in exchange for a recurring monthly fee — usually $50 to $80 — for a defined set of services.

This issue brief describes the landscape of DPC practices, which collectively have more than a half million people on their rolls.[1] It explores the opportunities and challenges for the DPC model, especially in light of the Affordable Care Act (ACA), and legislation in some states providing for the retainer practice model.

Because the field is too young for a detailed national study of its effectiveness in delivering cost-efficient quality care, this report relies on research on some of the early notable players. More than a dozen DPC organizations were included in the research, which involved interviews with payers, purchasers, and consumers. The DPC providers profiled were selected because they have significant market presence and/or major corporate/venture capital backing and they represent a geographic distribution nationally.

For the purposes of this report, DPC is defined as retainer practices that usually charge less than $100 per month per patient. The research excludes what are known as "concierge" practices, which charge higher fees and target more affluent patients.

History and Current Landscape

As recently as the 1950s and '60s, it was normal for patients to have a direct paying relationship with their physician. As the scope of health insurance expanded from primarily catastrophic coverage to payment for most facets of health care, the direct relationship between patient and primary care physician dwindled. One of the founders of the DPC movement, Dr. Garrison Bliss, said the change had a negative impact on patients, and also diminished the professional role of physicians:

> *"To a very real extent, when patients do not pay or control the payment to their physicians, their power and influence in health care declines. In the current fee-for-service health care insurance environment funded by employers and governments, physicians are paid for diagnosis and treatment codes."*

In what has been primarily a grassroots movement, other physicians in at least 24 states have sought to reinstate direct payment through DPC practices. DPC practices with national aspirations like Iora Health, MedLion, Paladina Health, Qliance, and White Glove Health have brought greater visibility to this approach to health care delivery. Supporters of this approach believe that DPC will have a role in helping solve the growing problems of diminishing access to primary care as well as its increasing cost.

April 2013

A significant recent development in the DPC market was the entrance of the publicly traded dialysis company DaVita in January 2012, which bought ModernMed, a health care services firm that provides direct primary care in 12 states through employer-based, on-site clinics and private physician practices. DaVita also bought HealthCare Partners, the country's largest operator of medical groups and physician networks, for over $4 billion. The DPC/onsite company is the foundation of DaVita's new division, Paladina Health. Some of the HealthCare Partners practices could eventually transition to a DPC model, according to company officials. DaVita has jumpstarted Paladina by enrolling DaVita's largest concentration of employees in Tacoma, Washington, with over 1,000 employees and dependents.

In another potentially significant development, Paladina is offering their self-insured employer customers a guarantee that overall health care costs will be lowered while maintaining or improving health outcomes. Paladina indicated that it has reduced costs for its current clients by 30%, in sharp contrast to persistent health care inflation elsewhere.

How DPC Differs from Insurance-Based Practices

In describing their value, DPC leaders point to the efficiencies gained from reducing administrative burdens related to insurance, as well as to reducing downstream costs, including emergency department visits, hospitalizations, surgeries, and specialist visits. While typical primary care practices receive less than 5% of the total health care dollar, DPC practices generally charge double this, arguing that by increasing primary care spending to about 10% of total health care costs, they can reduce downstream spending by more than this increment. DPC practices, they maintain, focus on keeping patients out of the expensive parts of the health care system, such as specialist offices, emergency departments, and hospitals. Iora, Paladina, and Qliance have each published outcomes studies claiming a 20% to 30% or more reduction in overall health care costs.

Due to smaller patient panels than insurance-based practices, DPC practitioners say they spend more time with patients discussing the trade-offs of particular screenings, treatments, and procedures. DPC practitioners frequently advertise their "unrushed 30-minute appointments." They describe the extra time as pivotal to reducing costs and improving outcomes.

DPC coverage is not comprehensive, and these types of practices often recommend that members obtain a high-deductible wraparound policy to cover emergencies and catastrophic events. Some efforts are underway to combine changes in plan design with the DPC purchasing methodology. To date, two insurance carriers have tailored offerings to DPC-based patients — Cigna and Associated Mutual. Cigna has paired its "Level Pay" program targeting self-insured employers with 50 to 250 employees and is offering this only to Qliance customers so far.

Associated Mutual has stated it is offering a wraparound policy but hasn't announced details yet. Physician Care Direct is working with DPC practices and networks, as well as multiple carriers, to facilitate wider adoption of the DPC model. They expect the combined cost of the DPC wraparound policy and DPC fees to be less than a standard health insurance plan.[2]

Table 1 shows five large DPC providers, along with their key accounts, number of patients, fee structures, and unique attributes.

Table 1. Five Large Direct Primary Care Practices

Iora Health	Dartmouth, Culinary Health Fund, Freelancers Insurance Company	2,400+	$80/month, average (based on risk-adjusted acuity)	Primarily near-site clinics for union-based organizations, insurers, and self-insured employers
MedLion	Declined to answer	3,000+	$59/month	Transitioning fee-for-service practices to DPC — supports hybrid insurance/direct practices Operates in CA, NV, WA Creation of onsite or near-site clinics for large employers or municipalities
Paladina Health	DaVita employees plus 20+ undisclosed employers	8,000+	$69 to $109/month plus varied levels of performance-based pay	Acquired ModernMed 24/7 access to patient's personal physician's cell phone Transparency tool Referral management Puts fees at risk based on achieving cost savings, patient satisfaction, and clinical outcome targets
Qliance	United Food & Commercial Workers, Expedia	7,200	$65/month, average	Most comprehensive list of services covered in monthly fee
White Glove Health	Highgate Hotels, Beryl Companies, Ivie & Associates	40,000 via self-insured employers; 450,000 via health plans	Up to $35/month plus $35/visit fee	House/office calls and remote care delivered by nurse practitioners overseen by doctors

Note: All monthly fees are per member, per month, unless otherwise noted.

Scope of Practice

Table 2 provides a list of services included in the scope of DPC practices (see page 4). Without a financial incentive to rapidly refer care to specialists, the scope of DPC care is generally broader than that of a typical primary care practice. For example, some DPC practices provide x-rays and EKGs that would typically be referred outside by an insurance-based primary care practice. While some of the listed services are outside the scope of the membership fee, they are generally offered at an additional cost.

Based on interviews conducted with DPC practitioners and their patients, a high percentage of DPC consumers are either uninsured or have high-deductible plans. They often seek guidance from DPC practitioners on keeping their non-primary care costs low. In many cases, according to interviewees, DPC providers refer patients to specialists who will offer significant savings off of the more generally available price in exchange for immediate payment and avoidance of the costs of billing and collections. Nextera, a direct primary care practice located in Firestone, Colorado, has arranged $300 CT scans, $425 MRI scans, and other steeply discounted prices. It is common for DPC practices — which often serve people who are uninsured or have high deductibles — to seek out organizations that give them a discounted case price. This is particularly common for imaging due to over-capacity. Paladina offers a mobile price-transparency app using Healthcare Blue Book data to inform their members of pricing.

Table 2. Services and Pricing of Selected Direct Primary Care Practices

✓ Included in monthly fee
$ Included in visit fee
$$ Available for extra fee

	Annual exam	Phone and email access	Basic x-rays	EKGs	Pregnancy tests	Spirometry	Blood draws	Flu shots	Consultations and coaching (1)	Chronic disease management (2)	Outpatient and hospital coordination	Urgent care (3)	Lab tests (4)	Casts	Splints (5)	Skin tag/mole removal	Vaccines	Membership Costs
AtlasMD Concierge Family Practice	✓	✓	$$	✓	✓	✓	✓	$$	✓	✓	✓	✓	$$	$$	$$	✓		$10 to $100/month depending on age (e.g., age 20 – 44: $50/month; age 45 – 64: $75/month)
Iora Health	✓	✓		✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		$60 to $80/month depending on patient complexity
MedLion	✓	✓	$$	✓	$$	✓	✓	✓	$$	✓	✓	$$	$$	$$	$$	$$	$$	$59/month plus $10/visit Vaccines, labs, etc., offered at cost
[illegible]	$$	✓		$	$	$	$	$$	$$	$$	✓	$$	$$	$$	$	$$	$$	$10 or $20/month (family: $50/month) Clinic and virtual visits: $20 per 15 minutes Transparent pricing on labs, etc.
Nextera Healthcare	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	$$	$$	✓	$$	$99/month
Paladina Health	Declined to respond																	$69 to $109/month plus varied levels of performance-based pay
[illegible] Proactive Healthcare	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	$$	$$		$60/month
Qliance Medical Management Inc	✓	✓	✓	✓	✓	✓	✓	$$	✓	✓	✓	✓	✓	✓	✓	✓	$$	$54 to $94/month depending on age Vaccines free for children in Washington, at cost for adults
Total Access Physicians PSC	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	$75/month (couple: $120, family: $150)
WhiteGlove Health	Declined to respond																	$35/month plus $35/visit

(1) Consultations and personalized coaching for weight loss, smoking cessation, and stress management.

(2) Chronic disease management for hypertension, diabetes, hyperlipidemia, heart disease, asthma, arthritis, osteoporosis, and many other conditions with referrals out to specialists when necessary.

(3) Same-day or next-day care for urgent medical issues including x-rays, sprains, strains, fractures, cuts requiring stitches, acute illnesses, and more.

(4) Laboratory tests including blood glucose (fingerstick), hemoglobin/hemotocrit, HIV screening test, INR (blood coagulation measurement), mononucleosis test, pregnancy test, stool blood test (FOBT), strep throat test, urinalysis.

(5) Ankle braces, forearm splint, finger splint, thumb spica splint, cast bootsurgical shoe, walker boot (short and long), wrist brace.

Note: All monthly fees are per member, per month, unless otherwise noted.

Market Forces and the Future of DPC

There are current market forces that support the growth of the DPC model, as well as factors that may inhibit its success. The following are factors likely to encourage growth:

- **Health reform act.** A DPC clause was written into the Affordable Care Act (ACA) allowing retainer practices to be included in the proposed insurance exchanges, with the caveat that these practices be paired with a wraparound insurance policy covering services outside of primary care. It is the only non-insurance offering to be authorized in the insurance exchanges slated to begin in 2014; however, there is no requirement that DPCs be included. See Appendix for more information.
- **Patient centeredness.** DPC's focus on closely coordinated primary care, affordability, and eliminating unnecessary referrals fits well with the goals of national and state health policy, as well as with patient interest; DPC is positioned to benefit from renewed focus on primary care led by large employers in support of patient-centered medical homes.[3]
- **Uninsured.** After full implementation of the ACA, ineligible individuals (including undocumented immigrants) are a continuing source of customers for DPC.
- **Capital funding.** Significant venture capital funding for disruptive care/payment models coupled with corporate backing such as DaVita's Paladina division as well as a large Blue Shield company (Cambia Health) investing in DPC pioneer Qliance.
- **The Health Benefit Exchange.** Health plans may see a market opportunity through the Exchange by coupling DPC with a high-deductible wraparound policy that promises to deliver a lower price than conventional insurance products. Cigna and Associated Mutual are early adopters of this strategy. In general, DPC offering is not a high priority for health plans.
- **Clinic convenience.** Some DPC providers use onsite and/or near-site clinics. The onsite model can be attractive for some large employers because it offers greater access and convenience for employees. Near-site clinics can be situated near a set of organizations where employees are covered. One major DPC provider uses this model to serve union members situated in geographic clusters.

However, a number of market forces may potentially inhibit the growth of DPC:

- **Low awareness.** To date, buyers of health care and primary care physicians know little about the DPC model.
- **Status quo.** The health care industry is historically slow to adopt new care or payment models unless mandated.
- **Resistance from competitors.** Reducing referrals to specialists and hospitals may threaten those providers, provoking resistance.
- **Resistance from insurers.** Some insurance carriers may perceive a disintermediation threat and seek to get regulatory relief.
- **Primary care squeeze.** Due to unfavorable economics of primary care, many practices are selling out to larger health systems, eliminating the DPC option.
- **Inadequate scale.** Most DPC practices are very small; as yet there is not enough scale to service larger national employers.

Authors

Dave Chase is the CEO of Avado, a patient relationship management company. He is the co-editor/writer of a book published in March 2013 on patient engagement titled *Engage! Transforming Healthcare Through Digital Patient Engagement.* He also contributes regularly to *Forbes,* TechCrunch, Reuters, and numerous health care publications.

Acknowledgments

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About the Foundation

The California HealthCare Foundation works as a catalyst to fulfill the promise of better health care for all Californians. We support ideas and innovations that improve quality, increase efficiency, and lower the costs of care. For more information, visit us online at [illegible].

Endnotes

1. Membership figures are an aggregate of self-reported figures from the DPC practices.
2. There remains a high degree of ambiguity in the pricing of "standard" plans as well.
3. According to the National Committee for Quality Assurance (NCQA), a patient-centered medical home (PCMH) is an innovative program for improving primary care. In a set of standards that describe clear and specific criteria, the program gives practices information about organizing care around patients, working in teams, and coordinating and tracking care over time. The NCQA patient-centered medical home standards strengthen and add to the issues addressed by NCQA's original program. The patient-centered medical home is a health care setting that facilitates partnerships between individual patients, their personal physicians, and when appropriate, the patient's family. Care is facilitated by registries, *information technology, health information exchange,* and other means to assure that patients get the indicated care when and where they need and want it, in a culturally and linguistically appropriate manner.

Appendix: Regulatory Backdrop for Direct Primary Care

The ACA authorizes HHS to permit qualified health plans (QHPs) to provide coverage through a qualified "direct primary care medical home" (direct PCMH) plan provided such coverage meets certain criteria (as developed by the Secretary of HHS) and that the QHP, meeting all other applicable requirements, ensures coordination of such services with the entity offering the QHP.

With respect to implementing guidance, this provision was addressed in 2012 in CMS Exchange/QHP final regulation, in which CMS codified the treatment of direct PCMHs. The provision authorizes QHP issuers to provide coverage through a direct PCMH that meets the standards established by HHS, provided that the QHP meets all standards otherwise applicable. CMS in its final rule addressed comments raised during the proposed rule-making process relative to what those standards might look like, noting in the final rule that direct PCMHs need not be accredited in order to participate in QHP networks. However, CMS "encourage[d] QHP issuers to consider the accreditation, licensure, or performance of all network providers."

CMS opted in the final rule not to set firm requirements or thresholds that would necessitate that QHP issuers contract with a specified number or percentage of direct PCMHs. Thus, CMS in its final rule, does not direct that Exchanges create incentives for contracting with direct PCMHs; instead CMS "encourage[s] Exchanges to promote, and QHP issuers to explore innovative models of delivery along the care spectrum." Thus, there does appear to be an opportunity for Exchanges and QHP issuers alike to promote and include such models, but per the final guidance on this provision, there is no obligation to do so.

Forbes

Dave Chase Contributor
I cover/cover disruptive innovators reinventing healthcare

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Health Plan Rorschach Test: Direct Primary Care

Despite its inclusion in Obamacare, Direct Primary Care (DPC, aka Concierge Medicine for the Masses), it's surprising how few health insurance executives know about DPC. DPC is a model of paying for primary care outside of insurance. The individual or organization paying for healthcare pays a monthly fee (like a gym membership) for all primary care needs. Generally, DPC providers say they can address 80 or more of the top 100 most common diagnoses.

the fourth blot of the Rorschach inkblot test (Photo credit: Wikipedia)

Once I explain DPC to insurance executives, I have found it's an excellent Rorschach test reflecting whether that executive's organization is playing to win or is back on their heels regarding the wrenching changes that are reshaping healthcare from the DIY Health Reform movement as well as the effects of Obamacare. For example, rapid growth of self-insuring by corporations is a trend pre-dating Obamacare but many expect it to accelerate as self-insuring gives companies down to 20 employees more flexibility than Obamacare rules allow.

Forward-looking health plans view DPC as part of a broader strategy to reinvent themselves. For example, the parent company of a large Blue Shield recently invested in the pioneer of DPC, Qliance. Conversely, health plans that are back on their heels simply look at it as a way they will get disintermediated. This DPC Rorschach test will presage how that health plan will fare in the coming years. For example, some will discount it as only applicable for a certain segment of the population such as the "worried well" yet I've found the exact opposite. For example, the Grameen Foundation (famous for its Nobel Prize-winning founder known for microfinance) has brought it to low-income populations in New York that the [illegible] reported on. In Washington state, DPC is now being used with Medicaid populations.

Over the years, the California Health Care Foundation (CHCF) has commissioned [illegible] outlining trends affecting healthcare. Just as they wrote about retail clinics several years ago as they began to emerge, they wanted a similar analysis done for DPC. The CHCF asked me as

I've studied DPC perhaps more than anyone other than those operating DPC businesses. Many ask why I have OCD on DPC. My answer is twofold.

1. There is a lot to learn from organizations demonstrating the Triple Aim (lower costs, improved outcomes, better consumer experience). I've yet to see any model that more consistently delivers on the Triple Aim than DPC.
2. When you found a tech startup, you make a bet on how the future will unfold so that you can get there before your competition. Our bet a few years ago when we began has now become obvious — healthcare will become more patient-centric, accountable and coordinated. In other words, virtually the opposite of the "do more, bill more" model that is bankrupting our country. My belief is DPC is a microcosm of the future healthcare system so I've been studying it and working with DPC providers the last few years. Naturally, DPC providers have a fundamentally different set of requirements than traditional players so it is helpful in shaping our decisions. *See The Marcus Welby/Steve Jobs Solution to the Medicaid-driven State & County Budget Crisis for what I wrote earlier.*

The CHCF published the [illegible] I wrote in April. It is a good summary of what I have learned. CHCF papers have a neutral, objective tone which is appropriate for their role. However, I have formed opinions about DPC so I'm publishing here my raw perspective on DPC starting with an introduction. Please see the introduction and history of DPC below.

[Contact me via [illegible] if you'd like a copy of the full seminal study on the Direct Primary Care model]

Introduction

This paper provides the landscape of an emerging practice model called Direct Primary Care (DPC) sometimes referred to as "concierge medicine for the masses". There are over a half million people in DPC practices. With DPC legislation passed in some states and inclusion in the Affordable Care Act (ACA), the implications, successes and obstacles to DPC growth are explored. The field is too young for detailed national studies so some of the early notable players were studied. Over a dozen DPC organizations were studied as well as interviewed payers, purchasers and consumers to gain their perspective on the DPC model. In state regulatory and legislative language these practices are sometimes referred to as "retainer practices, " and are defined as those that charge a recurring monthly fee in exchange for a set of services.

Direct Primary Care is defined as retainer practices that charge less than $100 per month per patient. Most charge in the $50-80 per month range. Of note, we are not including in this definition practices that continue to bill insurance companies for their services but charge in addition a monthly fee to patients. While these practices are able to provide additional time and resources to their patients, they are still largely driven by the current fee-for-service business model, and subject to its limitations.

History

Just a few decades ago, it was the norm to have a direct paying relationship with one's physician, whether it was cash or bartering some product or service. As health insurance expanded from primarily catastrophic coverage to payment for all facets of healthcare, the direct relationship between patient and provider deteriorated. One of the founders of the Direct Primary Care movement, Dr. Garrison Bliss, articulated the changes in healthcare payment and their effect as follows:

> *"To a very real extent, when patients do not pay or control the payment to their physicians, their power and influence in health care declines. In the current fee-for-service health care insurance environment funded by employers and governments, physicians are paid for diagnosis and treatment codes.*

Bliss goes on to say that the result of these changes has led to a decline in the perceived value of primary care, a massive dependence on medical technology and a focus on higher cost procedures over effective, results-oriented health care.

Brian Klepper, PhD, and David C. Kibbe, MD, MBA outline the roots of valuing specialist care at the expense of primary care in a piece about the playing field being extremely tilted towards specialists in this [illegible]. Part of the transition back to patient-driven care began with the first concierge practice, opened in Seattle in 1996 by Howard Maron and Scott Hall. It was called MD2 ("MD squared") and charged $1,000 per member per month. Shortly thereafter in 1997, also in Seattle, Garrison Bliss and Mitch Karton converted Seattle Medical Associates from a fee-for-service insurance Internal Medicine practice to a maximum $65 per monthly fee Direct Primary Care practice. This is currently a three- physician practice that remains highly successful and popular. Dr. Bliss later went on to establish Qliance Medical Group of Washington PC, the first scalable Direct Primary Care practice designed for the mass market.
Bliss and Karton determined that a panel size of 800 for their combined practice would be the break-even point. 1600 would be a full practice. (i.e., 2 MDs with 800 patients each). Bliss and Karton designed their DPC practice with the following design principles that persist to this day:

- Work for our patients directly – know who's the boss (the patient).
- Give the providers and the patients time to do the job right. Keep the panel sizes low and expectations high.
- Be open when patients need you to be open (12-hr days, weekends) and/or accessible electronically.
- Don't charge insurance co-pays or deductibles.
- Don't pay providers to do anything but the right thing for our patients -- no incentives to "do stuff" as the fee-for-service model has encouraged.
- Build an electronic medical record that does medicine, not insurance billing.
- Monthly fees go to care, not an "insurance bureaucracy tax".
- Frequently ancillaries are either free or at cost such as lab tests and prescriptions.

Within a year of Seattle Medical Associates converting its practice to Direct Primary Care, yet another innovative practice in Seattle – SimpleCare – was created by Vern Cherewatenko, M.D. and David MacDonald, D.O. Dr. Cherewatenko describes what led them to switch their model:

> We both had excellent business staff and business-wise ran a very tight ship. Our combined practice billings totaled over $10 million, not a tiny operation by any means. With a combined annual practice billing of $10 million we calculated that we were losing approximately $7 per patient or $80,000 per month.

They realized they couldn't make it up in volume. With 2 clinics, 55 providers and 75,000 patients, they needed 6 clerks just to deal with copying of records from patients transferring in and out of various managed care plans. They analyzed their average patient charges and they described it as follows:

- Their charge for a 10-minute patient visit was $79.
- The insurance companies typically reimbursed $43

- Costs of collection were anywhere from $5-20 depending on the staff time, billing system, etc. (All doctors know they are discounted, but most doctors overlook what it costs to *collect* the $43).
- Therefore, the actual fee reimbursement for a $79 charge was $23.
- With a single, all-inclusive exam room overhead at $30 (the national average), they discovered they were losing about $7 on each of the 75,000 patients they were seeing annually.

This analysis caused them to rethink what they had taken for granted.

> "We knew we could not cut our overhead any further– we had been doing that for the past 2 years (cheaper copy paper, less fancy patient info, less nurses, less receptionists, no more "pantry stocking," and so on). We were running as lean as we could, practically on bare bones."

Extent of Direct Primary Care

Although DPC practices are currently evolving primarily as a grassroots movement and most of these practices make little effort to obtain national recognition, they have been identified in at least 24 states and are burgeoning in several regions including California, Florida, Washington State and Texas. With the advent of scalable versions of DPC practices with national aspirations like Iora Health, MedLion, Paladina Health, Qliance, and White Glove Health, it is this author's opinion that the DPC movement will grow rapidly in the coming decade, particularly if the US health care system fails to find other solutions to the problems of declining primary care, high cost, accessibility and poor performance.

Note that some of the DPC providers profiled in this paper also offer additional primary care options such as near-site and on-site clinics. The care delivery model is essentially the same, however they offer their services only to a limited number of employers.

Cottage DPC Industry Emerges

After the first DPC practices formed in Seattle, an array of entrepreneurs followed the model pioneered by Dr. Garrison Bliss or simply came up with a model on their own, unaware that others had begun to develop similar practices. Some of the notable pioneers include Drs. Vic Wood of Primary Care One in West Virginia, Brian Forrest of Access Healthcare in North Carolina, and Samir Qamar of MedLion in California. In addition, venture-backed White Glove Health in Texas developed a model with Nurse Practitioners making house calls.

By sheer numbers, White Glove Health is the most successful DPC organization, with over 500,000 members. The others all have fewer than 5,000 patients thus far. Not all DPC practices have had quick success. For instance, Symbeo based out of New Jersey raised and then burned through capital before it became economically sustainable.

The entrance of the highly successful dialysis company, DaVita, is one of the biggest recent developments in DPC. They bought a DPC/onsite clinic company ModernMed, a healthcare service firm providing direct primary care in 12 states through employer-based, on-site clinics and private physician practices. Later, they bought Healthcare Partners, the country's largest operator of medical groups and physician networks, for over $4B. The DPC/onsite company is the foundation of DaVita's new division, Paladina Health. Some of the Healthcare Partners practices could transition to a DPC model. DaVita has jumpstarted Paladina by enrolling DaVita's largest

concentration of employees in Tacoma, Washington with over 1,000 employees and their dependents.

Even more recently, Qliance has received a major infusion of capital from Cambia Health (parent company of a regional Blue Shield). This is one of the best signs that health plans are beginning to wake up to the DPC opportunity. Qliance's previous investors have been founders of some of the most successful technology companies of the last 20 years – Amazon, aQuantive, Dell and Expedia.

Five Largest DPC Providers:

	Key Accounts	# of Patients	Fee structure	Unique attributes
Iora Health	Dartmouth, Culinary Health Fund, Freelancers Insurance Company	2,400+	Per member, per month (PMPM) based on risk adjusted acuity, currently averaging approx $80 PMPM	Primarily near site clinics for union-based organizations, insurers, and self insured employers
MedLion	Primarily individuals	2,000+	$59/mth + $10 copay	Transitioning fee-for-service practices to DPC – supports hybrid insurance/direct practices; operates in CA, NV, WA
Paladina Health	DaVita employees + 15 undisclosed employers	8,000+	$85-$125 PMPM	Acquired ModernMed;Concierge-level physician access; Transparency solution;Puts fees at risk based on achieving cost savings, patient satisfaction, and clinical outcome targets
Qliance	United Food & Commercial Workers, Expedia	5,000+	Average $65 PMPM	Most comprehensive list of services covered in monthly fee
White Glove Health	Highgate Hotels, Beryl Companies, Ivie & Assoc	40,000 via self-insured employers; 450,000 via health plans	Up to $35 PMPM + $35 per visit fee	House/office calls & remote delivered by nurse practitioners overseen by doctors